The Modern Hospital

APRIL 1955

Use of Color in Hospitals

Planning Central Supply

Jefferson Medical College Hospital

New Approach to Statistics

Press Relations

How Free Are Our Hospitals?

JEFFERSON MEDICAL COLLEGE HOSPITAL, PHILADELPHIA

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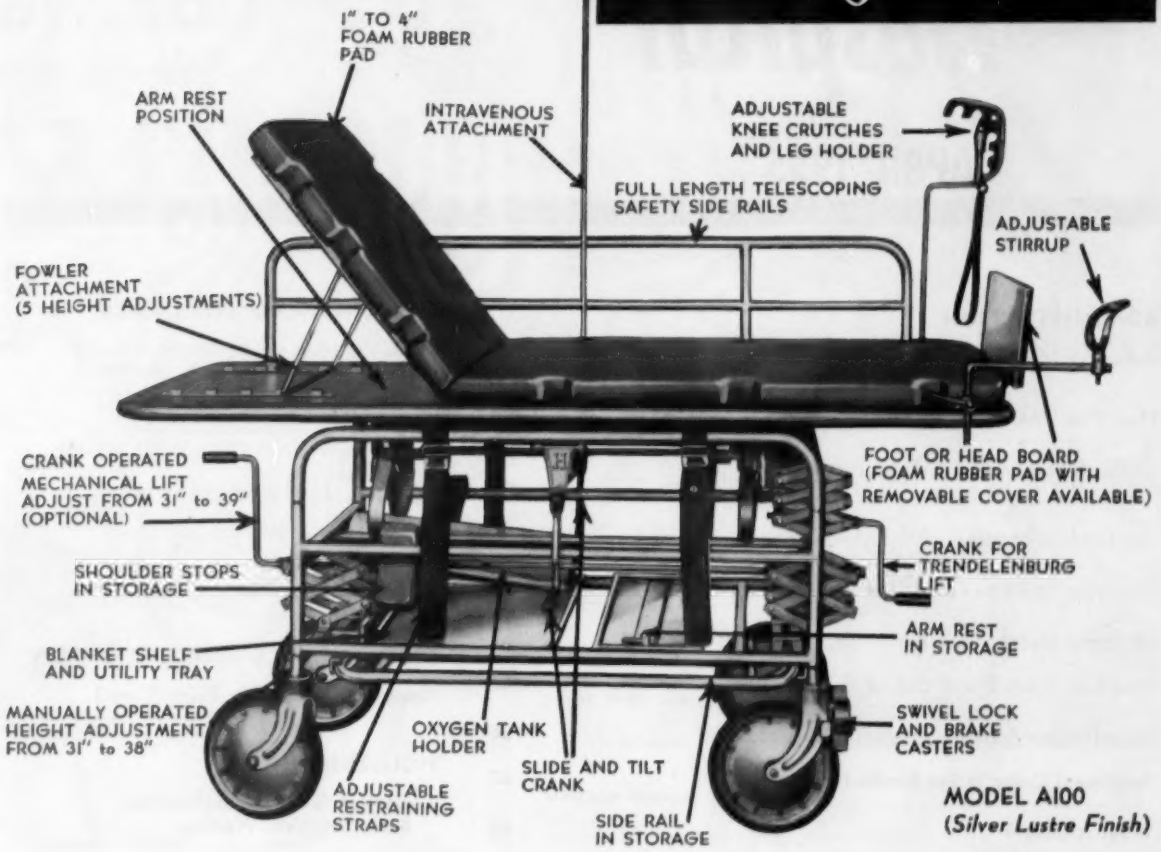

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The Modern Hospital

APRIL 1955

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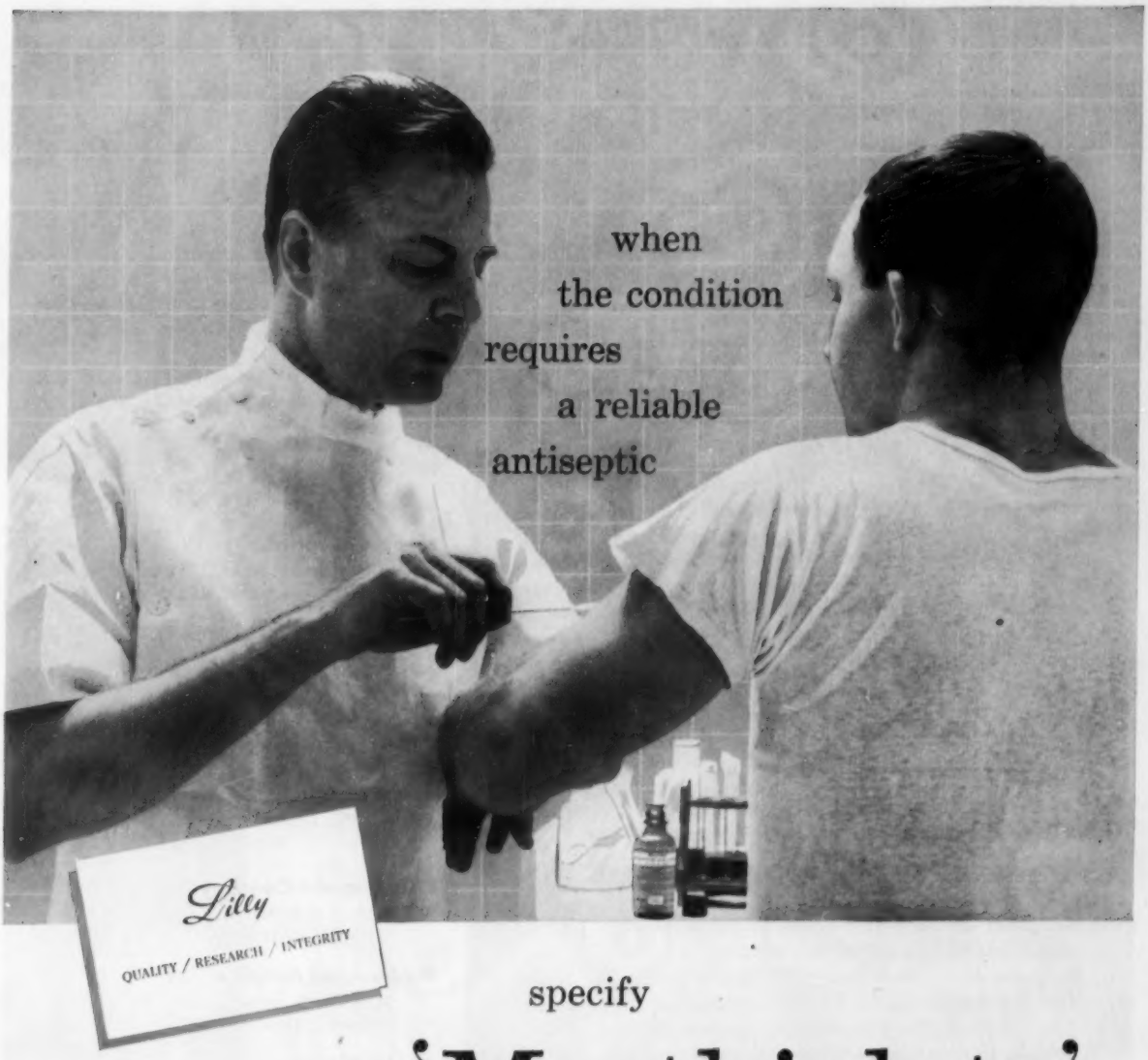

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AMONG THE AUTHORS


Granger Westberg

Rev. Granger Westberg is chaplain at the University of Chicago Clinics and associate professor of theology at the university. A pioneer in the field of hospital chaplaincy, the Rev. Mr. Westberg has been president of the chaplains' section of the American Protestant Hospital Association. Before going to the University of Chicago in 1952, he was chaplain at Chicago's Augustana Hospital for eight years. Following his ordination as a Lutheran minister in 1939, he had his own church in Bloomington, Ill., for several years before entering hospital work. Chaplain Westberg has just published a book for nurses entitled "Nurse, Pastor and Patient." His observations on the responsibility of nurses for the spiritual welfare of hospital patients appears on page 82.

Howard Ketcham, author of the article on the functional use of color in hospitals (*p.* 65), is a color consultant for business and industry. As head of his own firm in New York City for the last 20 years, he has developed new color-styling themes for more than 500 products, ranging from automobiles, office machines, and household appliances to planes, ships, locomotives, houses and industrial equipment. A graduate of Amherst College, Mr. Ketcham was art director for an advertising agency before organizing his own business. As an officer in the navy during World War II, Mr. Ketcham developed a series of standard camouflage colors for navy shore installations and helped to coordinate army and navy painting practices. He is the author of several books on color and art and serves as an editor or consultant on color to a number of magazines. In the article on page 65, he discusses the importance and application of correct color coordination in the modern hospital.

Dr. Marta Fraenkel is director of medical statistics and records of the New York City Department of Hospitals, a position she has held for the last six years. Her interest in the morbidity of hospitalized patients and her concern about a reporting system which would use diagnostic and related data on hospital patients as current sources of morbidity data date back many years, to the time when she wrote a book on the subject, "The Hospital Discharge Study," with Neva R. Deardorff as co-author. The article on page 75 of this issue summarizes some of the ideas Dr. Fraenkel has developed in detail in a forthcoming report, "Morbidity in New York's Municipal Hospitals."


Lewis B. Perry Jr.

Lewis B. Perry Jr. is personnel officer at the University of California Medical Center in San Francisco. A graduate of the University of California, Mr. Perry has a master's degree in public administration. He has worked in the university's nonacademic personnel program since 1949, specializing in job classification and wage administration for laboratory, scientific and medical-related personnel. He has been personnel officer of the medical center since 1950.

Boynton S. Kaiser, co-author with Mr. Perry of the nurses' salary study on page 81, is chief personnel officer of the University of California, a position he has held for the last 12 years. He is also a lecturer in the university's department of political science and teaches a graduate course in public personnel administration. The department which Mr. Kaiser heads at Berkeley started in 1942 with two employes and now has a full-time staff of 48, with local offices on seven of the eight university campuses.

READER OPINION

Suspect Nursery Suspect

Sirs:

While looking over The Modern Hospital of the Month in the January issue I observed that the suspect nursery apparently communicates directly with the regular nursery.

This is a practice which is frowned upon by many health authorities, and rightly so, and I am surprised that it cleared the Hill-Burton people. In these days of shortage of personnel the temptation is too great and short cuts will be taken. Would it be proper for you to call this to the attention of the architects? The regular entrance from the hallway is already there and it will simply mean throwing up a wall.

I do have this suggestion to make. Why have a suspect nursery as such? In a well regulated hospital such a unit is seldom used more than a couple of times a year.

In Rochester we were confronted with the necessity of making our nurseries conform with the new Sanitary Code Regulations of the State of New York. Each unit of two nurseries had a suspect unit adjacent to it. Investigation revealed that they were used as catch-alls (storage) for things that should have been returned to stores or central supply and were used as intended about twice a year. By cutting out the wall between the isolation and regular nurseries it was found possible to meet the new regulations with existing space.

The isolation nursery as an autonomous unit was abolished. It was my contention that if an isolation nursery was needed it would be just as simple to take a single adult patient room for the short period that isolation facilities were needed. In this way you did not have expensive space lying idle. This "radical" change was put into operation and maintained for two years before I left and is still in operation with absolutely no complications.

In new construction isolation nurseries should be omitted.

Robert H. Lowe, M.D.
Wheaton, Ill.

Why Men Were Omitted

Sirs:

In reading Dorothy Schworm's article in the February issue of The MODERN HOSPITAL, I would like to call your attention to the fact that the brochure "Executive Housekeeping as a Career" was passed on by the national board, *before* the amendment of Article III on Membership was passed by the vote of the delegates at Congress.

Naturally, since men are eligible for membership in our association, our next brochure would be along entirely different lines.

Rosalie V. Soper
President
National Executive
Housekeepers Association
Denver

Wants Articles Summarized

Sirs:

In reading over some of the articles hastily and others thoroughly, it has occurred to me many, many times—why don't we have a summary preced-

A surgeon tells you what he wants from a surgeons glove

"My grandfather remembers when they didn't have surgeons gloves—and then when they had them but no one wore them. Insistence on protection for doctor, nurse and patient has changed things since those days. Today, if I can get good sensitivity and comfort during long operations, I'm satisfied. Those two features, economy for the hospital, and protection are what I look for in a surgeons glove."

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ing the article or at the end of the article digesting a complete article?

I realize that in a scientific paper a summary is more practical than in some of the articles written in your magazine. However, with all the reading material that passes over any administrator's desk, it would be nice to read a magazine with the summary first and then if we felt that more information was needed, the entire article would be worth reading.

Leonard W. Hamblin
Deaconess Hospital
Freeport, Ill.

Adopts Dichter Ideas

Sirs:

You might be interested in what we are doing in our own hospital in an attempt to achieve the type of hospital-patient relations described in the articles by Ernest Dichter in The MODERN HOSPITAL.

Actually we had begun thinking along these lines even before the articles appeared. We had also been thinking along these lines when we started to survey our patients after they left the hospital. But The MODERN HOSPITAL articles focused our thinking. We added a survey of our medical staff to our program. And we decided to do a little educational work of our own.

We reprinted excerpts of the series, along with a covering letter, which we mailed out to our entire medical staff, both attending and courtesy, as well as to a number of doctors throughout northern California who have had dealings with our hospital in some way; copies of this reprint also were distributed to our lay board of directors, to every member of our women's auxiliary, and to every person on our hospital staff, professional and otherwise, from members of the house staff and nurses to elevator operators and porters.

Already the hospital is beginning to show results, not in the solution of all problems, naturally—it is too soon for that—but in a general ferment of thinking along these lines. We expect the next year to show some concrete improvement in making Mount Zion the kind of hospital where our patients *feel* well cared for.

There already has been a gratifying community response as well. The Northern California Psychosomatic Society and the San Francisco Hospital Conference have decided to co-sponsor a panel discussion of Patient-Hospital-Doctor Relations which will be held at Mount Zion Hospital in April. Mark Berke, director of Mount Zion, will be one of the speakers, and social workers, doctors and nurses from all over northern California will be invited to attend. This meeting was a direct result of the reprint of the Dichter articles which we mailed out, as described.

Michela Robbins
Director of Public Relations
Mount Zion Hospital
San Francisco

"Cure" Is Effective

Sirs:

The article "Salt Lake Hospitals Take the Cure" was excellent. It should be a stimulation to all institutions to "put their house in order."

Like so many other hospitals, we are not without need for a very critical self-appraisal. In order to create an awareness of this problem, we are anxious to circularize our staff with reprints. Would it be possible to obtain 30 copies of the article?

Matthew F. McNulty Jr.
Administrator
Jefferson-Hillman Hospital
Birmingham, Ala.

Could you cut laundry costs with modern washers?

Are your laundry costs as low as they ought to be?

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Roving Reporter

Irish Hospitals Sweepstakes

Three times a year, holders of Irish Sweepstakes tickets all over the world, and particularly in the United States, cross their fingers and hope for the best in the Big Draw, but in Ireland there is always one group of winners regardless of what numbers are drawn from the drums at the Hospitals Trust headquarters in Balls Bridge, Dublin, or how the nags come in once the race is run.

The year-in, year-out winners of the Sweepstakes are the Irish hospitals which receive one-fourth of the total proceeds under an Act of Irish Parliament. Under the law, the first Sweepstakes took place on the Manchester November Handicap in 1930.

When one visits the Sweeps headquarters now where some 2000 people make up the permanent staff, with another 2000 added before each of the three Sweepstakes annually, the growth of the program is evident, but Jack O'Sheehan, director of draws and publicity, recalls the days when the Sweepstakes was just a dream of his and Joseph McGrath, former Minister of Trade and Commerce, and some of the other Irish patriots who fought for and won the country's independence in the rebellion of the 1920's. Once the law was passed, it became the job of the enthusiasts to find the money to set up headquarters for and to conduct the Sweeps with no sure knowledge of how successful it would be.

Interestingly enough, one of the opponents of the Sweepstakes in the beginning, but which now shares in the benefits willingly and eagerly, was Dublin's famous Rotunda Maternity Hospital. The Rotunda was opposed to gambling, although it was founded in 1745 on money raised from a lottery.

The first Sweepstakes resulted in some £417,485 with the hospital's share a cool £131,798, more money than anyone had seen in one lump in a long, long time.

It is not hard for the visitor to Ireland to imagine the hospital situation in 1930 when the little country was emerging from its long struggle for independence won only eight years before after a bloody rebellion which left her exhausted physically and financially. Not the least of the problems was how to provide hospital and medical care for those already in need and for future generations.

All over Ireland, the merging of the old and new is quite apparent. Perhaps in the hospital field, it is most evident. Architecturally, the hospitals may be divided into four main groups:

First, there are the old hospitals, monstrosities of brick or stone, centuries old, which were either designed as hospitals or were adapted from existing buildings. Currently, the old buildings are either undergoing reconstruction and modernization, or, if that is impossible, are being razed and rebuilt on new sites.

In the second group are the hospitals planned and built in the inter-war period, which show the results of the first Sweepstakes. In the 1930's, 12 new county hospitals, 30 district and fever hospitals, two new mental hospitals, and a new maternity hospital

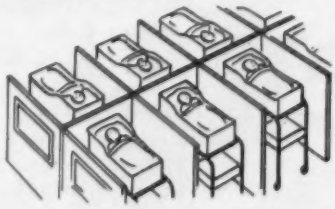
Ward in National Maternity Hospital, Ireland, built with lottery funds.

New 2-Way BASSINET

1. FOR ROOMING-IN TECHNIQUE
or
2. FOR CUBICLE ARRANGEMENT IN NURSERY

ROOMING-IN TECHNIQUE

The bassinet is wheeled from the nursery to the mother's room. The entire unit is light in weight and moves easily on rubber-tired swivel casters. Extra-long extension base slides under bed, brings basket and supplies within easy reach for mother to work on infant.



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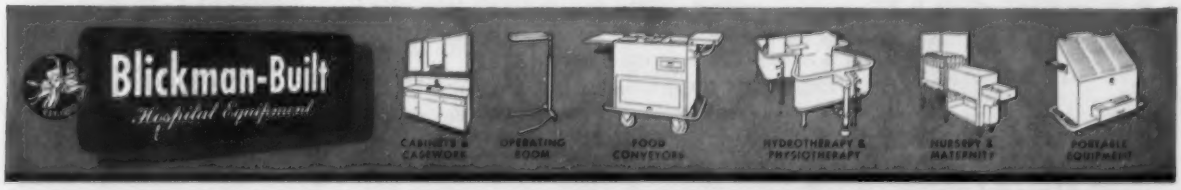

You are welcome to our exhibit at the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., Booths No. 29 and 30, April 20-22. Also to our exhibit at the Catholic Hospital Association Convention, Kiel Auditorium, St. Louis, Mo., Booths No. 200-204, May 16-19, and to the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N.J., Booths No. 314-316, May 25-27.

were completed. Extensive improvements were made on existing hospitals.

The third group of hospitals consists of those designed before World War II on which construction was delayed, to be begun at an almost frantic rate since 1947. The plans on these hospitals required much alteration because of the changes of materials and designs and of the higher costs of building material in the postwar world.

Fourth, there are the sanatoriums and special hospitals, which are going forward at a great rate and which may be the most exciting phase of the entire hospital program. These hospitals include maternity, orthopedic, cancer, mental illness, and tuberculosis institutions. The sanatoriums, for the most part, are regional in nature and are criticized by some who prefer the homey atmosphere of the smaller institution as "too big, too impersonal, and too sterile," but the hospital authorities argue that only through these 300 to 500 bed institutions can the job be done quickly and economically.

Roughly, the postwar building program involves construction of 15 new general hospitals, ranging from 64 to 486 beds; one new fever hospital; four new maternity and children's hospitals; 10 mental hospitals; nine tuberculosis institutions; one cancer hospital; 13 nurses' homes, and 30 extension and modernization projects.

How much this enormous project has been aided by Sweepstakes funds can be best understood with a glance at the figures. Out of 80 Sweepstakes, the hospitals of Ireland have received some £30 million, well over $100 million, a nice amount even in the United States where building costs and labor might be double or even triple that of Ireland.

Admitting the weakness of medical research in the Irish hospitals, but bound by law to distribute the money to institutions caring for the sick poor within the boundaries of Ireland, the Irish Medical Research Council was established legally in 1937, and has operated on a yearly allocation out of Sweepstakes funds. The grants from the council are open to citizens of all nations and such projects as cortisone research, cancer and so on have been recipients of these grants.

The drawing of the Sweepstakes is always a dramatic event. In the presence of representatives of the trustees for the Prize Fund, trustees for the Hospitals Fund, the Hospital Commission, the Hospitals Committee, and the police commissioners, nurses draw the numbers from the drum where the subscribers' ticket stubs have been placed. Ten counterfoils are then drawn for each horse (53 horses). Everyone whose number is drawn receives something while those numbers on the winning horse are eligible for first prizes of £50,000, about $140,000 at the current rate of exchange.

The Sweeps are controlled by the Associated Hospitals Committee and carried out by Hospitals Trust, Limited, an incorporated company of organizers engaged for that purpose under the management of Joseph McGrath, manager of Hospitals Trust. Grants are studied and recommendations are made to the Minister of Health by the Hospitals Commission.

Perhaps because everyone participates voluntarily in the Sweeps, or perhaps because the memory of the poverty of the pre-Independence days is still fresh in the mind of many an Irishman, the public generally seems to have a feeling that the hospitals belong to them and takes a possessive pride in the growing program.—BARBARA CALLAHAN.

Hospital personnel interested in any phase of oxygen therapy are invited to write for Ohio Chemical's new 40-page brochure describing the most complete therapy oxygen service available. Since this is a rather costly piece of literature, we must limit its distribution to key personnel. Please favor us with your complete name and title when filling out the coupon.

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McKeesport Hospital

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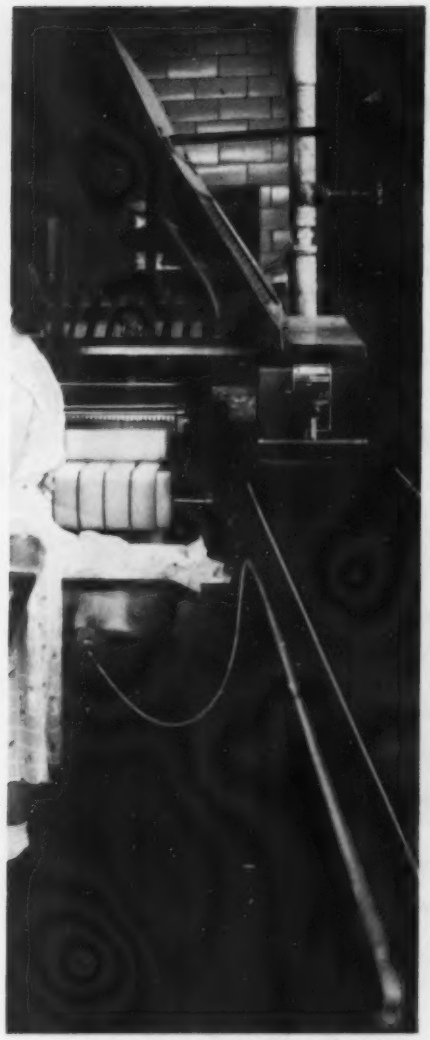
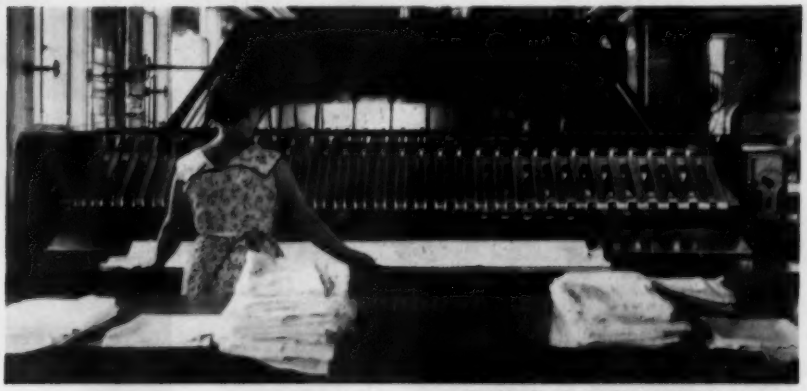


Heart of the Operation. From Rotaire Tumbler, conditioned large flatwork goes by Conveyor to Sager Spreader. Here pieces are opened and straightened automatically for fast feeding to 8-Roll Super-Sylon Ironer. Conveyor at extreme right takes small flatwork to another Conveyor running across ironer front.

First Step. Extracted work is emptied onto table where operator places individual pieces on Feed Conveyor to 48 x 84" Rotaire Continuous Conditioning Tumbler.



Finishing Up. Type 4-FS Trumatic Folder automatically and rapidly folds large linens as they come from the Super-Sylon Ironer.

ups laundry output 153%

BIGGEST FACTOR: New American mechanized flatwork ironing!

With American Mechanized Flatwork Ironing, production increases because work-flow is continuous. Flatwork is heat- and moisture-conditioned, then conveyed to ironer for top quality, high-speed ironing and folding. Work is delivered directly to operators' best working positions. There's no confusion, fewer manual operations.

The McKeesport, Pa., Hospital's mechanized one-ironer installation *helped increase production 153%*, and released an extra shift of seven operators. With work better organized and far less fatiguing, operator morale has reached a new high.

Whether your laundry department has one ironer or several, American Mechanized Flatwork Ironing can work production and labor-saving wonders. For more information, call in your American Laundry Consultant.

It costs no more to air condition with quality Yorkaire conditioners

You can be sure of getting the *right kind* of air conditioning — with Quality equipment made by York!

quality You Can See

- *Handsome appearance* . . . unquestionably the handsomest air conditioning units ever designed.
- *Hermetically sealed* . . . the entire cooling circuit is sealed against trouble like a light bulb. Dirt and moisture can't leak in, refrigerant can't leak out.
- *Full 5-Year Protection Plan* . . . other quality features: rust-resistant finish, tamper-proof controls, structural steel construction.

quality You Can Feel . . . You Can Hear

- *Greater cooling capacity in less space!* Staggered tubes and corrugated fins travel the air further in the cooling chamber. More York quality features include draft-free operation, York's unique "V" coil, fresh air circulation, extra-capacity condenser.
- *All-weather comfort!* On models equipped with Atmostat, a flick of the switch takes care of those days when it's the humidity, not the heat. All refrigerant in *half* the cooling coil wrings excess moisture from the air *without* over-cooling!

- *No annoying rattles, gurgles or clicks* . . . just the soft hum of a skillfully made precision instrument. York's exclusive capillary tube feed eliminates expansion valve. No noisy moving parts to get out of adjustment. Still more quality features include rubber-mounted fan motor, fan section and compressor, and thermal and acoustical insulation.

See how Yorkmanship has made possible the right kind of air conditioning at no extra cost. See your York Dealer. He is listed in the classified directory. York Corporation, York, Pennsylvania.

YORK CORPORATION

York refrigeration and air conditioning

the quality name in air conditioning

HEADQUARTERS FOR MECHANICAL COOLING SINCE 1885

By using
the right colors
in the right places...

DU PONT COLOR CONDITIONING

helps
patients
feel better...
increases
staff
efficiency

Every day more and more hospitals all over the country are discovering how much Du Pont Color Conditioning contributes to patient morale and staff efficiency. By using the right colors in the right places, this scientific painting plan creates cheerful, relaxing surroundings . . . eliminates the institutional look. It gives lobbies, corridors, wards and rooms a "get-well" atmosphere that actually helps patients feel better! And in work areas, scientifically chosen colors improve visibility and increase staff efficiency.

Du Pont Color Conditioning costs no more than ordinary painting; it actually costs less in the long run. And new paint formulas make Color Conditioning Paints *odorless* during application! Now you can put this scientific painting plan to work for you without the annoyance so often caused by paint odors! To discover the many ways Du Pont Color Conditioning can pay off for you, mail the coupon today!

FREE 32-PAGE BOOK! *Find out how Color Conditioning can meet the specific needs of your building interiors. Get this book, illustrated in full color. Mail the coupon today!*

Du Pont Color Conditioning Paints Are Now Odorless

Now you can paint busy areas without interrupting normal routine

DU PONT

Better Things for Better Living . . . *through Chemistry*

E. I. du Pont de Nemours & Co. (Inc.)
Finishes Division, Dept. H-54
Wilmington 98, Delaware

Gentlemen:

Please send me, at no extra cost, your 32-page book, "Du Pont Color Conditioning."

Name _____

Title _____

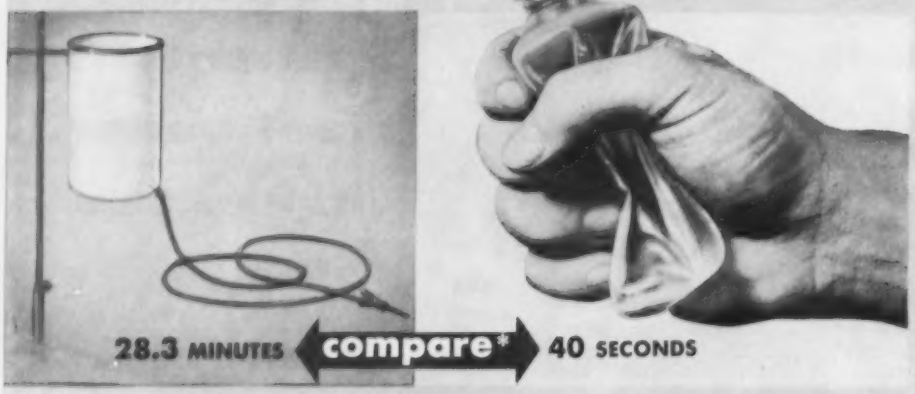
Address _____

City and State _____

When you save TIME
you save MONEY

FLEET ENEMA *Disposable Unit*

NOW AT A NEW, LOWER PRICE



It takes only *40 seconds* to prepare and administer a routine enema with the Fleet Enema Disposable Unit. Using cumbersome, old-fashioned equipment, preparation plus instillation plus "clean-up" and sterilization consumes *28.3 minutes.*

Only FLEET ENEMA Disposable Unit *offers these conveniences* . . . one hand administration . . . sanitary, individually sealed rectal tube . . . built-in rubber diaphragm to control flow, prevent leakage.

Each individual 4½ fl. oz. unit contains, per 100 cc., 16 gm. sodium biphosphate, and 6 gm. sodium phosphate, an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.

**From a soon-to-be-published time-cost study.*

"Phospho-Soda", "Fleet" and "Fleet Enema" are registered trademarks of C. B. Fleet Co., Inc.

C. B. FLEET CO., INC. • LYNCHBURG, VIRGINIA

Manufacturers of "Phospho-Soda", a laxative of choice for over half a century.

POLAR WARE goes all the way to meet your requirements in Catheter Trays

No. S-3004

No. S-170

No. S-125

No. S-83

In catheter trays — as in everything else — Polar will go to any length to meet the needs of the hospital clinic for enduring, aseptic stainless steel ware.

This super-long, thirty-inch tray is a case in point — produced by Polar to meet the sterilizing and storage requirements of the new rigid-type plastic catheters. And like all Polar Catheter Trays, it features seamless, heavy-gauge stainless steel construction, with rounded corners for absolute sterility.

You're sure to find just what you are looking for in the complete Polar line — and often, as in this thirty-inch tray — you can't even find it anywhere else. For this big reason, and many more, the best supply houses from coast-to-coast carry Polar Ware. Ask the men who call on you about this leading line.

Polar Ware Co. * 4300 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54 Room 1100-1101 | *415 Lexington Ave. New York 17, N. Y. | *123 S. Santa Fe Ave. Los Angeles 12, California | Offices in Other Principal Cities *Designates office and warehouse

Have you tried all three?

"Specialist"®

EXTRA-FAST-SETTING

For clubfoot, fore-arm and other casts where an extremely fast-setting bandage is desired.

2" x 3 yd. 4" x 3 yd.
3" x 3 yd. 6" x 3 yd.

For walking-boots, long-term casts—and wherever maximal strength, minimal weight and effective moisture-resistance are essential.

3" x 3 yd.
4" x 3 yd. 6" x 3 yd.
4" x 5 yd. 6" x 5 yd.

"Specialist"®

FAST-SETTING

The bandage of choice for all general cast work.

2" x 3 yd. 5" x 5 yd.
3" x 3 yd. 6" x 5 yd.
4" x 5 yd. 8" x 5 yd.

Johnson & Johnson

but for ALL hospital personnel

Control of many pathogenic bacteria is achieved by soaps or detergents containing . . . **G-11®**

(Brand of Hexachlorophene)

G-11 is accepted by surgeons throughout the country as the antiseptic ingredient that effectively de-germs the skin without a prolonged scrub-up.

You can minimize hand transference of many pathogenic bacteria by specifying soaps and detergents containing G-11 for all personnel for all uses—for food handlers, technicians, clerical, custodial and maintenance help and others—as well as for nurses and patients. And remember, products containing G-11 are of utmost importance for the care of new-born infants in the hospital nursery. The use of soaps with G-11 not only can make your hospital cleaner and safer, but can also help to reduce the incidence of secondary infections associated with dermatitis.

Contact your supplier now for liquid, powder and bar soaps containing G-11.

SINDAR® Corporation
Industrial Aromatics and Chemicals
330 West 42nd Street, New York 36, N. Y.

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STATIC ELECTRICITY CAN'T START...

when hospital floors are protected by U. S. Conductive Rubber

Dangerous electric static-charge cannot accumulate with U. S. DURITE HOSPITAL FLOORING. Made of conductive rubber, this material is not only sparkproof and skidproof, it is also permanent flooring, easy to clean and extremely good-looking. DURITE *is easily and quickly placed over existing flooring.*

The Bureau of Mines, in its study of the static-electricity hazard in hospitals, says that "operating-room floors must be made of conductive materials." For such a purpose, hospital authorities can place complete reliance on U. S. DURITE. Every square foot of area is tested to resist 25,000 to 1,000,000 ohms. DURITE HOSPITAL FLOORING is approved by Underwriters' Laboratories, Inc. and the National Fire Protection Association (Bulletin 56). Available from any of United States Rubber Company's 27 District Sales Offices, or write address below.

"U. S." also makes anesthesia tubes of conductive rubber.

"U.S." Research perfects it..."U.S." Production builds it...U.S. Industry depends on it.

UNITED STATES RUBBER COMPANY

MECHANICAL GOODS DIVISION · ROCKEFELLER CENTER, NEW YORK 20, N. Y.

Hose • Belting • Expansion Joints • Rubber-to-metal Products • Oil Field Specialties • Plastic Pipe and Fittings • Grinding Wheels • Packings • Tapes Molded and Extruded Rubber and Plastic Products • Protective Linings and Coatings • Conductive Rubber • Adhesives • Roll Coverings • Mats and Matting

announcing
a new era in
corticosteroid therapy

METICORTEN

METACORTANDRACIN SCHERING

two new crystalline
adrenocorticoids
first discovered and
introduced by *Schering*

In a planned search for more effective substances without undesirable actions, two new crystalline corticosteroids have been discovered in Schering's research laboratories.

Possessing three to five times the therapeutic effectiveness, milligram for milligram, of oral cortisone or hydrocortisone in rheumatoid arthritis, other so-called collagen diseases, intractable asthma and other allergies, and nephrosis, METICORTEN and METICORTELONE are strikingly devoid of undesirable side actions, particularly sodium retention and excessive potassium depletion. Patients treated with these new steroids do not exhibit fluid retention, and sedimentation rate is lowered even where cortisone or hydrocortisone ceases to be effective—"cortisone escape." These new compounds afford better relief of pain, swelling and tenderness, diminish joint stiffness and are effective in small dosage.

.....*and* METICORTELONE

METACORTANDRALONE SCHERING

METICORTELONE, which resembles METICORTEN in clinical effect, is now being studied and will be available as soon as possible. The therapeutic properties of both drugs are being studied in other fields of therapy.

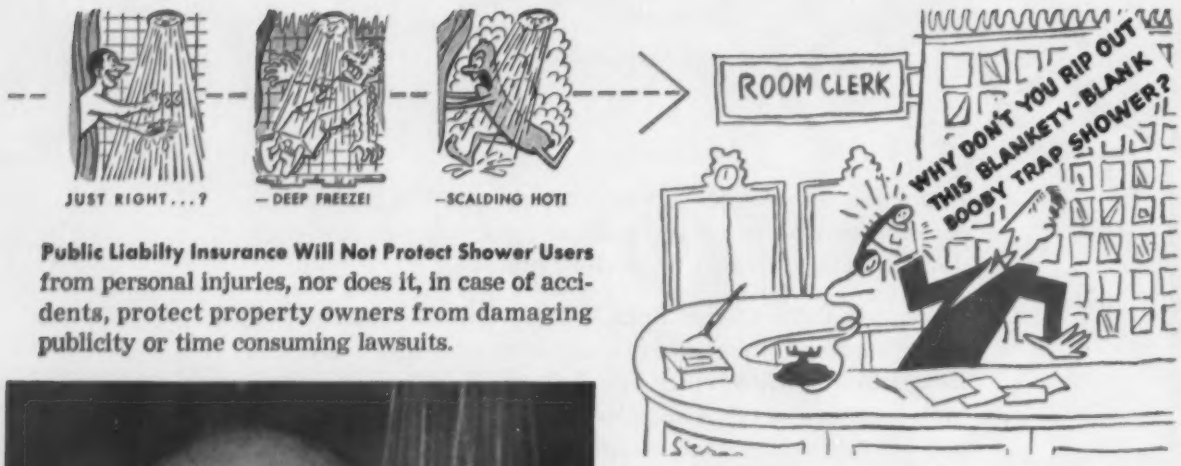
The first of these, METICORTEN, is being made available as 5 mg. tablets, bottles of 30. In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5 to 20 mg. is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime.* Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty.

METICORTEN,* brand of metacortandracin.
METICORTELONE,* brand of metacortandralone.

SCHERING CORPORATION • BLOOMFIELD, N. J.

SCHERING

*T.M.



Public Liability Insurance Will Not Protect Shower Users from personal injuries, nor does it, in case of accidents, protect property owners from damaging publicity or time consuming lawsuits.

End Shower Complaints

with

Double-Safety

of

POWERS

Thermostatic WATER MIXERS

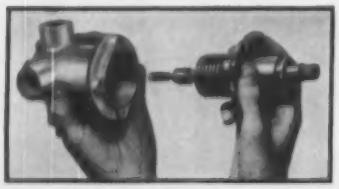
They protect bathers from scalding and "shots" of hot or cold water, caused by—

1. **PRESSURE or**
2. **TEMPERATURE**

fluctuations in water supply lines

Only a **thermostatic** water mixer gives this **double-safety**

Refreshing, Relaxing Safe Showers
and water economy too, are assured by Powers Thermostatic Water Mixers



One moving part easily accessible from the front. Easy removal of thermostatic motor and valve assembly with only a screwdriver makes it possible to inspect, clean or flush out mixer. Powerful thermostatic motor gives quick, positive shut off if cold water supply should fail.

No Shower Is MODERN Without This Protection

Powers thermostatic water mixers *always* hold shower temperature constant wherever the bather wants it. They are completely automatic. Failure of cold water supply instantly shuts off the shower. Delivery is *thermostatically* limited to 115° F.

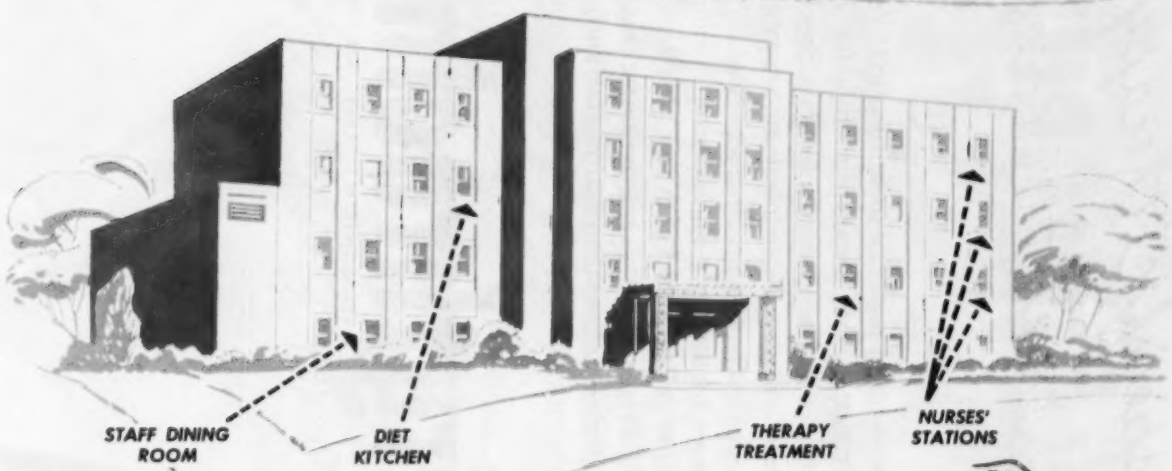
POWERS Mixers Save Water. No time or water is wasted by bather having to get out from under shower because of fluctuating shower temperature. Water conservation feature alone makes Powers mixers a profitable investment.

"Minimum of Maintenance" . . . report many users of Powers Type H Thermostatic Water Mixers. Their simple, durable construction insures years of dependable service. (b63r)

For Utmost Comfort, Safety and Economy Install Powers Mixers • Write for Bulletin 365

Established in 1891 • **THE POWERS REGULATOR COMPANY** • SKOKIE, ILL. • Offices in Over 50 Cities

SCOTSMAN ICE MACHINES
on every floor!



Save time . . . Save work . . . Save Money

Whatever your ice needs — there is a SCOTSMAN Automatic *Super Flaker* or *Super Cuber* to meet every one. The SCOTSMAN SC-100 *Super Cuber* is ideal for stations on every hospital floor. This low priced efficient *Super Cuber* will save time, work and money by providing low cost, sparkling, sanitary Super Cubes . . . big, round, solid, longer lasting cubes.

When flaked ice is needed for cold packs or therapy the SCOTSMAN *Super Flaker* supplies dry, hard, free-flowing Super Flakes. Super Flakes are made quietly without grinders, choppers or knives, using a mechanism which is the most dependable, yet simplest, ever designed.

Warm weather brings heavy ice demands. Now is the time to write for complete information and facts about SCOTSMAN —America's only complete line of ice machines designed and priced for every hospital need.

For kitchen and staff dining rooms SCOTSMAN *Super Cubers* are available in sizes which produce from 110 to 500 pounds of big, sparkling, pure, solid, round Super Cubes daily. Super Cubes are made with the exclusive SCOTSMAN "Cycle-Matic" control that guarantees perfect cubes every harvest—cubes that are actually purer than the water from which they are made!

Super Cubers
produce up to 500 lbs. of cubes daily.

Super Flakers
produce up to 1050 lbs. of flaked ice daily.

AMERICAN GAS MACHINE CO.
Division of Queen Stove Works, Inc.
Dept. MH-45 • Albert Lea, Minnesota

Please send me full information on SCOTSMAN Ice Machines

Name_____

Address_____

City_____ **State**_____

Against streptococci

This is an actual sensitivity test with a strain of *Streptococcus pyogenes* on a blood agar plate. Note the high activity of ERYTHROCIN against this organism. This same streptococcus may be associated with *sinusitis . . . otitis media . . . tonsillitis . . . pneumonia . . . empyema . . . pharyngitis . . . septicemia . . . tracheobronchitis . . . streptococcal sore throat . . . scarlet fever . . . erysipelas . . . certain urinary tract infections* . . . and *certain cases of subacute bacterial endocarditis* and *osteomyelitis.*

specific therapy against the cocci...

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that is specific therapy for most bacterial respiratory infections. Specific therapy—because these infections are caused by staph-, strep- or pneumococci. *And the cocci are the very organisms most sensitive to* ERYTHROCIN. In fact, you'll find ERYTHROCIN more active against this group of organisms than many other antibiotics.

filmtab

Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

Against common intestinal flora

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect growth of this organism—while the other antibiotics show marked inhibitory action. Since ERYTHROCIN is inactive against gram-negative organisms, *it is less likely to cause alteration in common intestinal flora—with an accompanying low incidence of side effects.*

...with little risk of serious side effects

The main reason is because ERYTHROCIN acts specifically. It destroys only harmful coccic invaders—yet doesn't materially change normal intestinal flora. *Thus, your patients rarely get side effects from* ERYTHROCIN. Nor do they get the allergic reactions sometimes seen with penicillin therapy. *Filmtab* ERYTHROCIN (100 and 200 mg.) comes in bottles of 25 and 100. Won't you prescribe *Filmtab* ERYTHROCIN—soon? Abbott

filmtab **Erythrocin®** STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

Of Money-Saving -TOUGH DINNERWARE!

No Matter How Rough You Treat Them, They'll Cut Your Replacement Costs!

● **Ever since** this amazingly durable dinnerware was introduced, food servers have been urging us to fill out the line. Now, here it is—a complete set of CORNING *Double-Tough* Dinnerware!

● **Every** beautiful piece will save you money! Double-Tough's durability is unmatched. Its beauty will last and last and last. No matter how rough your help and customers treat these pieces—you will cut replacement costs materially!

NOW 21 DOUBLE TOUGH ITEMS

● **Twelve additions** have been made. Above is the entire line—twenty-one pieces of dinnerware and four styles of tumblers. Why not standardize on CORNING *Double-Tough* right now! See your authorized CORNING Double-Tough Equipment Dealer today!

CORNING DOUBLE-TOUGH

COMPLETE LINE OF DINNERWARE AND TUMBLERS

Made by the Maker of Famous **PYREX** *Brand Ware*

CONSUMER PRODUCTS DIVISION, CORNING GLASS WORKS, CORNING, NEW YORK.

Sanacoustic* Ceilings provide strength-building, relaxing quiet so necessary to patients' progress

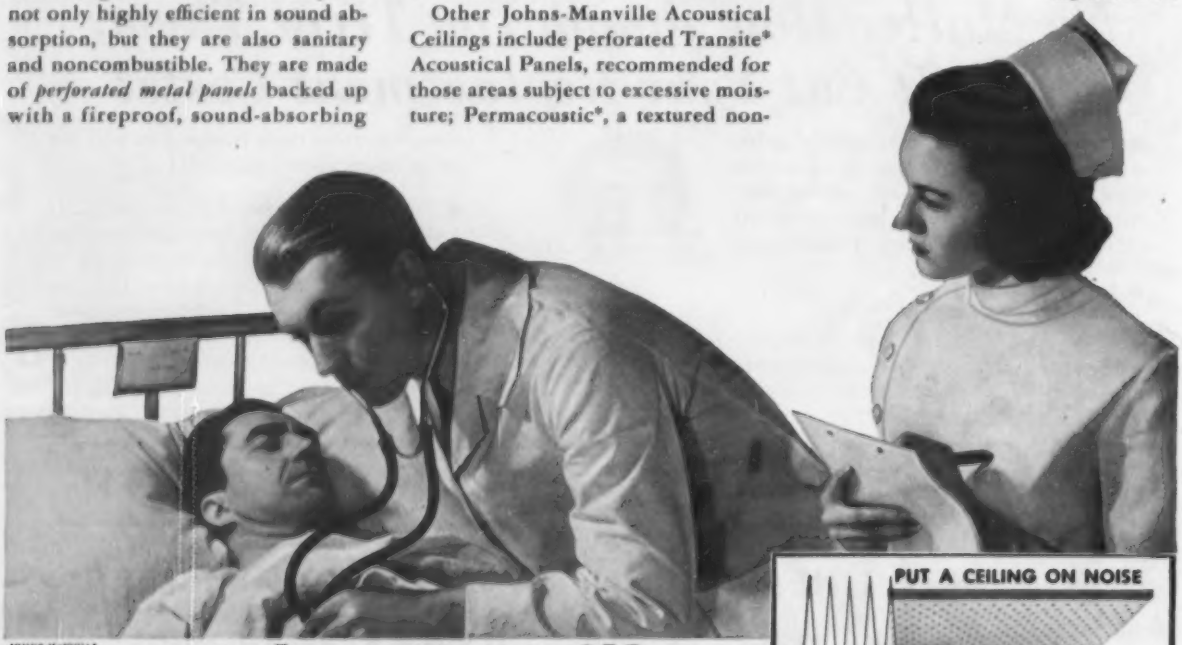
IN MODERN HOSPITALS TODAY, sound control is considered essential to the welfare of patients. *Quiet* speeds recovery.

Sanacoustic Ceilings offer hospitals one of the most effective methods of combating harmful noise. They are not only highly efficient in sound absorption, but they are also sanitary and noncombustible. They are made of *perforated metal panels* backed up with a fireproof, sound-absorbing element. The baked-enamel finish is easy to keep clean, and the ceiling can be washed or repainted without loss of efficiency. Sanacoustic units may be applied with new construction or over existing ceilings and are easily removed for access to services.

Other Johns-Manville Acoustical Ceilings include perforated Transite* Acoustical Panels, recommended for those areas subject to excessive moisture; Permacoustic*, a textured noncombustible tile; and Fibrestone*, a budget-priced drilled fibreboard unit.

For a free survey of your problems, or a free book on Sound Control, write Johns-Manville, Box 158, Dept. MH, New York 16, N. Y.

*Reg. U. S. Pat. Off.



JOHNS-MANVILLE PRODUCTS

Johns-Manville

40 years of leadership in acoustical materials

CUSTOMERS REPORT SAVINGS UP TO $4,000 PER YEAR

New RINSE-DRY method eliminates hand toweling, ends water spotting . . . of glasses, dishes, silverware!

Restaurant managers who take pride in their kitchens are singing the praises of this marvelous new Economics Laboratory contribution to automatic dish-washing!

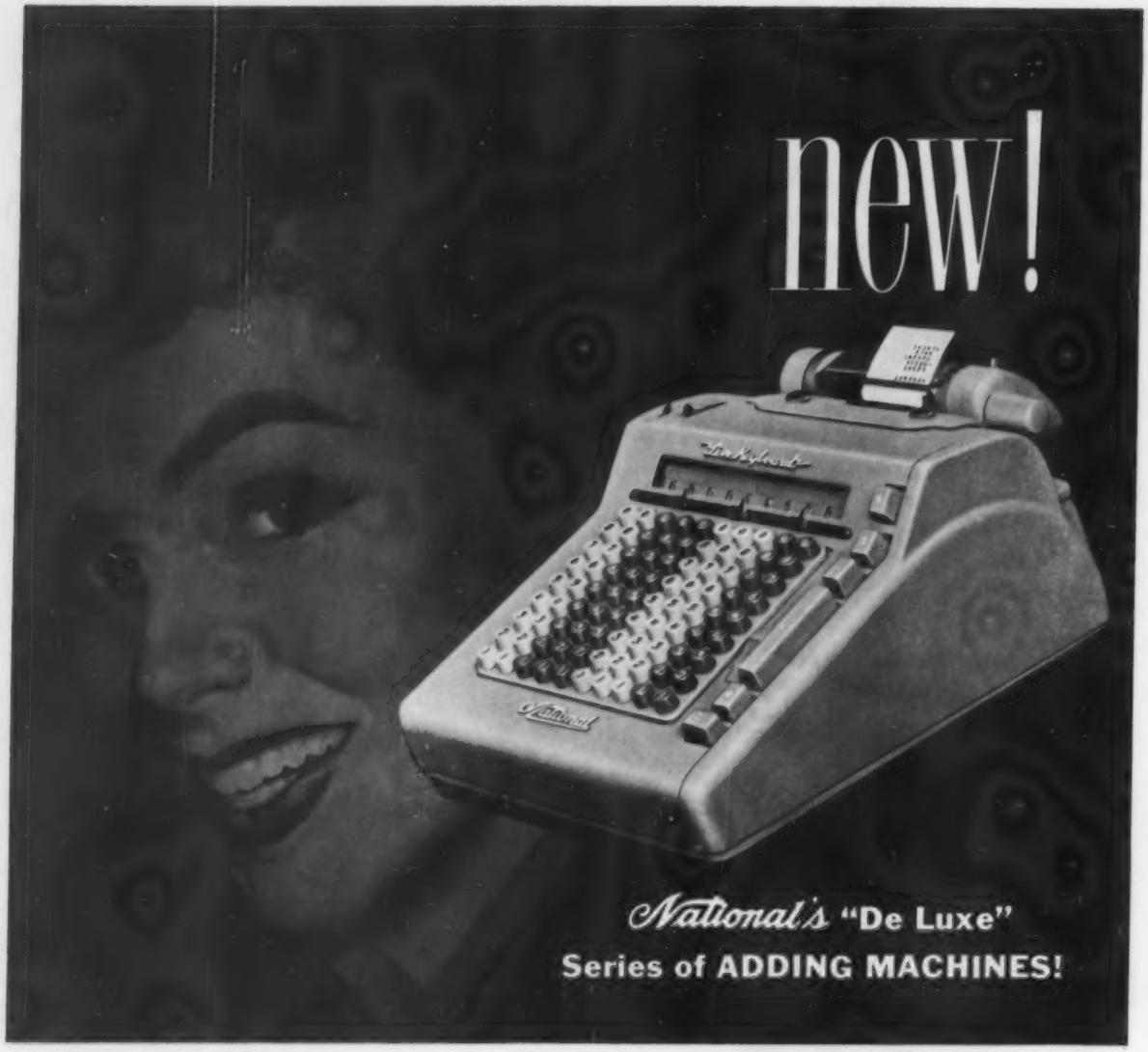
ENTIRELY NEW! RINSE-DRY solution is a concentrate of a new drying agent that cracks the surface tension of the water—causing it to slip off in sheets rather than stand in droplets. Dishes, china, silver, come right from the dishwasher sparkling clean, completely dry, without a trace of water-spotting.

GREATER EFFICIENCY—saves time and money! Never another minute's wait for tableware to dry. Never another hour of tedious toweling. No more need for special handling of silver and glassware. Depending on size of their operation, users report savings *up to $4,000 a year!*

COMPLETELY AUTOMATIC. The RINSE-DRY solution is pumped directly into the final rinse water by Economics Laboratory's new RINSE INJECTOR. It starts to work when the rinse system is activated. A signal sounds when the solution needs replenishing. The RINSE INJECTOR is adaptable to any type of dishwashing machine, quickly and easily installed by your SOILAX service representative.

For conclusive proof of remarkable savings—see your SOILAX service representative or write to ECONOMICS LABORATORY, INC., 250 Park Avenue, New York 17, New York.

EL ECONOMICS LABORATORY, INC.
250 Park Avenue, New York 17, N. Y.



"Live" Keyboard with keytouch adjustable to each operator!

Saves up to 50% hand motion —and effort!

Never before have so many time-and-effort saving features been placed on an adding machine.

Every key operates the motor — so you can now *forget the motor bar.* No more back-and-forth hand motion from keys to motor bar.

And keys are instantly adjustable to *each* operator's touch! No wonder operators are so enthusiastic about it. They do their work faster — and with up to *50% less effort.* New operating advantages! New quietness! New beauty!

"Live" Keyboard with Adjustable Keytouch *plus* 8 other time-saving features combined only on the National Adding Machine: Automatic Clear Signal . . . Subtractions in red . . . Automatic Credit Balance, in red . . . Automatic space-up of tape when total prints . . . Large Answer Dials . . . Easy-touch Key Action . . . Full-Visible Keyboard with Automatic Ciphers . . . Rugged-Duty Construction.

A National "De Luxe" Adding Machine is an investment that quickly pays for itself with the time-and-effort it saves, and then continues savings as added yearly profit.

One hour a day saved with this remarkable new National will, in the average office, repay 100% a year on the investment. See a demonstration, today, on your own work. Call the nearest National branch office or National dealer.

*TRADE MARK REG. U. S. PAT. OFF.

National

ADDING MACHINES • CASH REGISTERS
ACCOUNTING MACHINES

THE NATIONAL CASH REGISTER COMPANY, DAYTON 9, OHIO
949 OFFICES IN 94 COUNTRIES

If there's Du Pont Ludox® in your wax

Glistening floors can still be *safe* floors—if the floor wax contains "Ludox" colloidal silica, Du Pont's anti-slip ingredient.

Tiny, transparent particles of "Ludox" impart a unique "snubbing" action to the wax film—retard the shifting of wax particles under foot pressure. The result—added traction and added *safety* underfoot!

Try a wax containing "Ludox." You'll see how *safe* beautiful floors can be.

E. I. du Pont de Nemours & Co. (Inc.), Grasselli Chemicals Dept., Wilmington 98, Del. In Canada: Du Pont Company of Canada Limited, Box 660, Montreal.

Ask your maintenance man or janitor supply house for one of the many fine waxes on the market containing Ludox.®

DU PONT
REG. U. S. PAT. OFF.

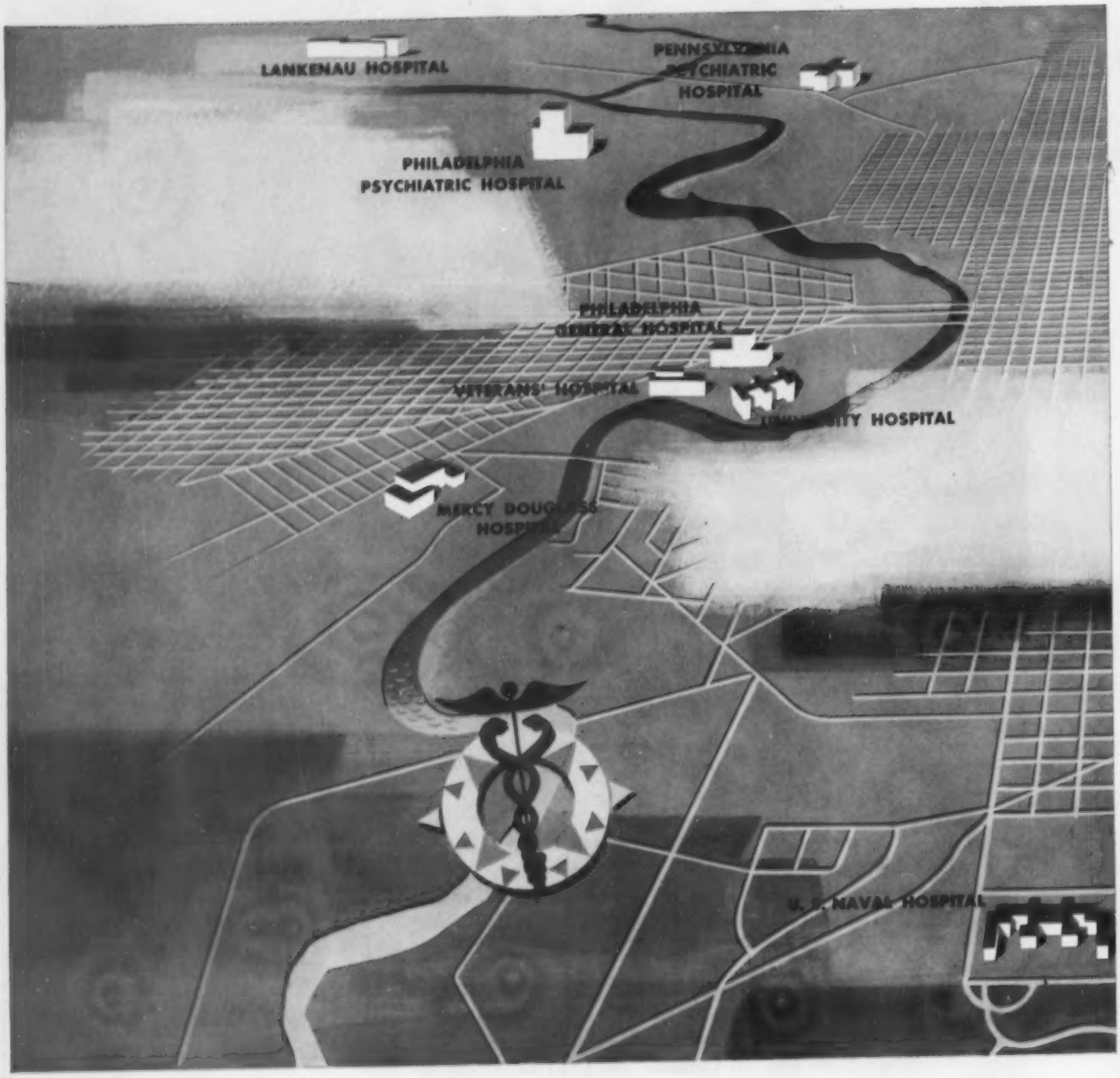
BETTER THINGS FOR BETTER LIVING
... THROUGH CHEMISTRY

For safety underfoot, specify floor wax made with

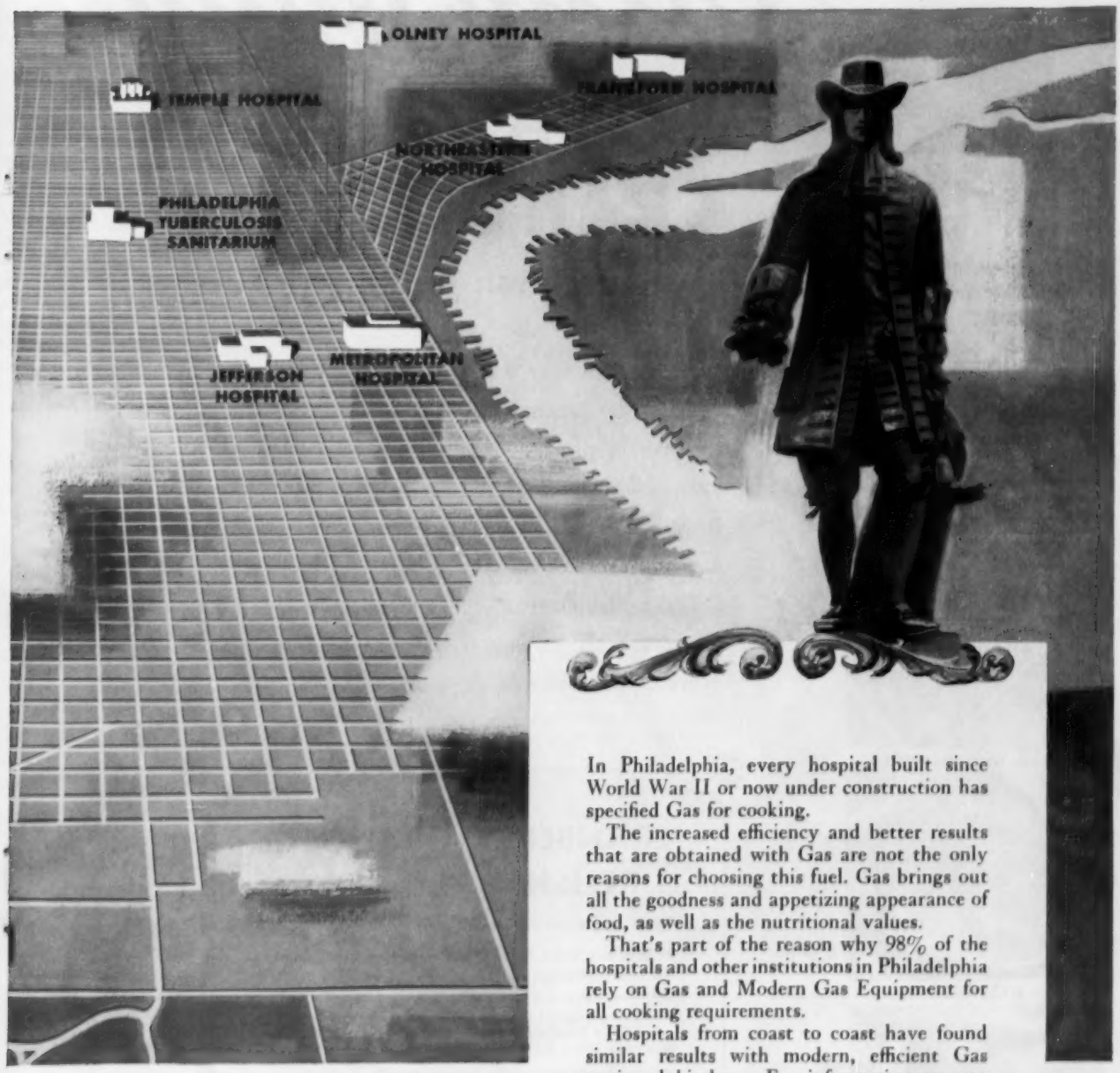
LUDOX®

Colloidal Silica

IN PHILADELPHIA, ALL THE NEW



HOSPITALS COOK WITH *GAS*



In Philadelphia, every hospital built since World War II or now under construction has specified Gas for cooking.

The increased efficiency and better results that are obtained with Gas are not the only reasons for choosing this fuel. Gas brings out all the goodness and appetizing appearance of food, as well as the nutritional values.

That's part of the reason why 98% of the hospitals and other institutions in Philadelphia rely on Gas and Modern Gas Equipment for all cooking requirements.

Hospitals from coast to coast have found similar results with modern, efficient Gas equipped kitchens. For information on any institutional feeding problem, call your Gas Company Commercial Specialist and discuss the economies and results Modern Gas Equipment can provide. *American Gas Association.*

SPECIAL INTRODUCTORY OFFER

Ocean Spray

FRESH-FROZEN CRANBERRIES

20% below fresh-Cranberry price

Use bargain-price fresh-frozen Cranberries to make delicious...

DESSERTS

BREAD AND MUFFINS

RELISHES

CRANBERRY SAUCE

Now, with more grower members in our Association to meet the demand for all Cranberry products, we can make a special offer of fresh-frozen Cranberries to institutions. These are the same top-quality, crisp, red berries families enjoy only in fresh Cranberry season—now available to you year round.

This introductory offer for frozen Cranberries is 20% lower than the average fresh-berry price. *Brighten a menu with Cranberries for less than 1¢ a serving!*

TESTED QUANTITY RECIPES ON REQUEST
OCEAN SPRAY FOOD SERVICE DEPT., HANSON, MASS.

CRANBERRY-ORANGE RELISH

(Easy to make during slack time)

¼ bbl. box (about 24 lb.) Ocean Spray fresh-frozen Cranberries
48 seedless oranges
24 lb. sugar

Put Cranberries and oranges (including rind) through food chopper. (Grind Cranberries while still frozen—easier to handle.) Add sugar.

This relish will keep under refrigeration for weeks, or may be frozen for later use.

Makes 28 qts. Relish (about 900 servings) at under 1¢ per serving.

Serve Cranberry-Orange Relish on relish trays, and with turkey and chicken plates.

IF YOUR DISTRIBUTOR CANNOT SUPPLY YOU, TELEGRAPH COLLECT TO:

**PERLEY MERRY
OCEAN SPRAY
HANSON, MASS.**

vivid . . . exciting . . . color!

FINE SERVICE requires COLOR . . . color to build hospitable atmosphere . . . color to whet appetites. And for colorful food service, there's nothing like Bolta's exclusive *laminated* color trays, available in 36 lovely color-and-pattern combinations. The exclusive 17-layer lamination adds years of extra wear. Bolta color trays will not warp, split or stain . . . they're impervious to cigarettes, acids and juices.

For finer service every day, serve it on a Bolta tray. **BOLTA PRODUCTS,** Lawrence, Mass., *A Division of The General Tire & Rubber Co.*

Bolta **TRAYS**

. . . add appeal to every meal!

6,300 volunteers put Akron Children's Hospital campaign over the top!

CHILDREN'S HOSPITAL
Akron, Ohio

Goal: $2,309,000
Pledged: $2,600,000

Proposed addition to Children's Hospital at Akron, Ohio • Administrator: Roger Sherman Architects: Wagner and Luxmore, AIA

Directing the activities of 6,300 volunteer workers is quite a job of organization! That was the task we faced recently at the Children's Hospital of Akron, Ohio.

This army of campaign workers did a magnificent job under outstanding volunteer leadership. *Without* solicitation in industrial plants or payroll deduction, the campaign went over the top by almost $300,000!

Mr. Lincoln Gries, president of the hospital's Board of Directors, says: "In a large measure, the success of this campaign from start to finish was due to planning and execution by the Ketchum organization."

This is just one of hundreds of hospital campaigns which have exceeded their objectives under Ketchum direction. A thoroughly trained and experienced representative will be happy to show you how professional direction can solve *your* fund-raising problems.

Consultation without obligation

KETCHUM, INC.
Campaign Direction

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA., AND 500 FIFTH AVENUE, NEW YORK 36, N.Y.
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Member American Association of Fund-Raising Counsel

Tiny new Frigidaire Ice Cubelets perfectly sized for hospital needs

Here's a wonderful new kind of ice that fits easily into water carafes, ice collars, ice bags or any small necked containers. Ends all the mess and bother of quick-melting, jagged, irregular crushed ice. Tiny new Frigidaire Cubelets are gems of pure, crystal clear ice only $\frac{3}{8}$" square (you select thickness—$\frac{1}{4}$" to $\frac{3}{4}$"). They're always solid, hard-frozen, uniform. Cubelets fill many kitchen and food service needs, too.

The Frigidaire Automatic Ice Cube Maker produces up to 200 lbs.—47,000 Cubelets—every 24 hours. Stores them in a sanitary porcelain bin. Even freezes out minerals and impurities so Cubelets are purer than the water they're made from.

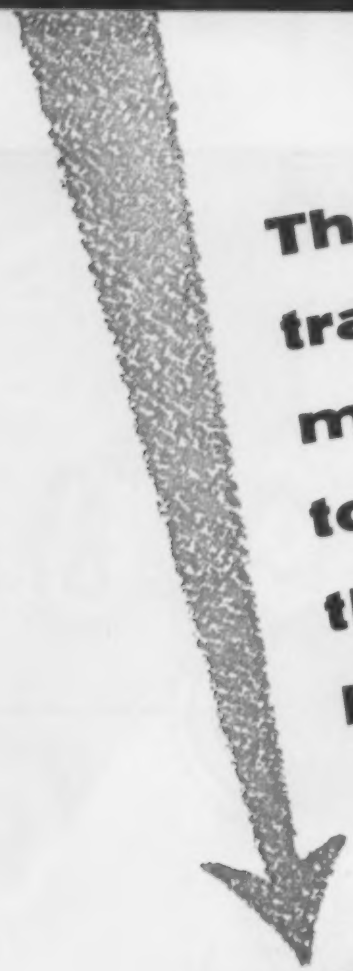
Ice Cubes are made the world's most trouble-free way! No grinders, chains or knives to make noise or break down. Silently, automatically the Frigidaire Ice Cube Maker fills to capacity, then shuts off—refills when supply drops. Choice of regular cube sizes or miniature Cubelets. Ask your Frigidaire Dealer about the Frigidaire Automatic Ice Cube Maker today.

**Construction meets the requirements of the New York City, N.Y. Department of Health.*

Compact, beautifully styled—put one or more on every floor of the hospital

Frigidaire Ice Cube Maker

BUILT AND BACKED BY GENERAL MOTORS



This trademark means more to you than ever before

Hall est. 1828

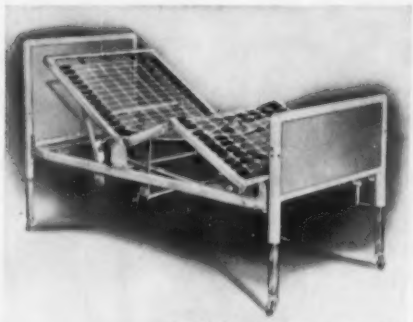
now a division of Royal

Frank A. Hall, Inc., world's oldest manufacturer of Hospital furniture and leading specialist in hospital beds, cribs and sides, is now a division of Royal Metal Manufacturing Co.

Royal is proud to add the fine technical products of the Hall firm to its lines, and to have the opportunity of offering the hospital field the stronger combined services and products that will now be available.

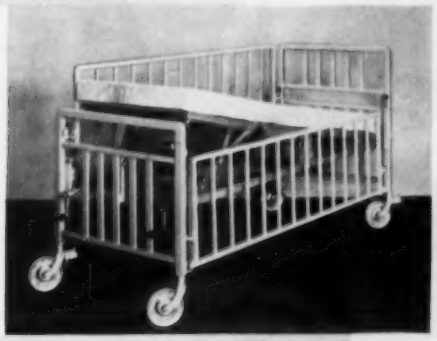
It is Royal's intention to perpetuate and expand the marvelous reputation and relationship which Hall has built with its customers over a period of 128 years.

ROYAL METAL MANUFACTURING COMPANY



Adjustable Height
CONVALESCENT BED

Crank adjusts from low to hospital height—gives full Fowler or Trendelenburg positions.



Johns Hopkins
RECOVERY BED

Excellent for post-operative recovery treatment and labor. Convertible to every professional use.

The Hall Hospital Bed

has long been regarded as the finest made. Shown here, are a few of the newest and most requested hospital beds developed by Hall and used extensively by such noted hospitals as the Jersey City Medical Center, Columbia-Presbyterian Medical Center, Cornell Medical Center, Johns Hopkins Hospital, Mount Sinai Hospital, and many others.

Hall Beds have proven their superiority over and over, since Hall's inception 128 years ago. A signature on your letterhead will bring complete information promptly, and without obligation.

General Utility
HOSPITAL BED

For recovery, eye, delivery, labor, neurological and convertible to a fracture bed.

Nickel Plated
CHILD'S CRIB

Finest crib made. Now fully nickel plated to protect finish for life of bed.

No. 1128
CHILD'S CRIB

Equipped with full safety features, pedal controlled sides, equal height sides and ends, correctly spaced upright fillers.

Hall
EST. 1928

FRANK A. HALL, Inc.
DIVISION OF
ROYAL METAL Mfg. Co.
175 No. Michigan Ave., Dept. 74, Chicago 1

Factories: Los Angeles • Michigan City, Ind. • Warren, Pa.
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Vina-Lux®

. . for long-wearing beauty on busy hospital floors

Roosevelt Hospital, New York City, York & Sawyer, Architects

Versatile Vina-Lux has everything your hospital needs in a floor . . long-wearing durability . . easy cleanability . . unusual beauty . . and a *quietness* both patient and employee will appreciate.

This modern vinyl-asbestos tile is tough and greaseproof. It has the strength and stamina to resist the heavy abrasive wear of constant foot and wheel traffic. It has a built-in resistance to the damaging effects of food greases, petroleum oils and solvents.

Because its surface is super-smooth and nonporous Vina-Lux can be cleaned and kept clean with minimum care. Periodic mopping keeps it bright and sanitary. And Vina-Lux colors are beautiful and distinctive . . a wide range of clean, bright colors to bring cheerful beauty to reception areas and corridors . . to patient rooms and wards.

Vina-Lux has another real plus for hospital floors. Its springy resilience brings welcome foot and leg ease and safer footing. It also makes for a quiet floor, muffling the noise of foot traffic and rolling equipment. Let Vina-Lux solve your hospital flooring problems, and do it at real savings per square foot per year. A qualified representative will call on you, at your request, to give you complete information.

AZROCK PRODUCTS DIVISION • UVALDE ROCK ASPHALT CO.

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AZROCK FLOORING PRODUCTS

TWO GREAT NAMES...

THE SHERATON-CADILLAC
DETROIT, MICHIGAN
One of the world's great hotels!

Equipped with

GARLAND

THE GREATEST NAME IN COMMERCIAL COOKING!

FAMOUS NAMES IN COMMERCIAL COOKING FROM COAST TO COAST DEPEND ON GARLAND!

Independent surveys prove again and again that Garland Commercial Cooking Equipment has more installations in leading hotels, restaurants, clubs, schools, and institutions than any other make! The reason is simply that men who know, *prefer* Garland quality, durability, dependability, and economy. If you have a commercial cooking problem, see your nearest food service equipment dealer now . . . and get the GARLAND story.

Gas—The Ideal Fuel—Supplied by Michigan Consolidated Gas Company

The battery formation illustrated includes: Spectro-Heat Hot Top; Open Top; Unitherm Fry Top; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes.

"EVERY SALE A DEALER SALE."

GARLAND

DM PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers
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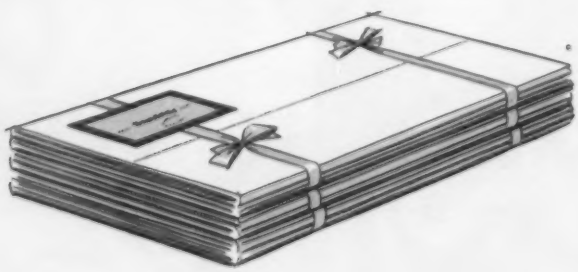
These famous hotel executives specify

Stevens UTICA-MOHAWK Sheets



for prestige . . . for economy

Muslin or percale sheets give *you* long service and your guests luxurious comfort. For complete details contact your own contractor or write J. P. Stevens & Co., Inc. for the name of the contract distributor nearest you.

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Fine Fabrics since 1813

Stevens Building, Broadway at 41st St., New York 36, N.Y.

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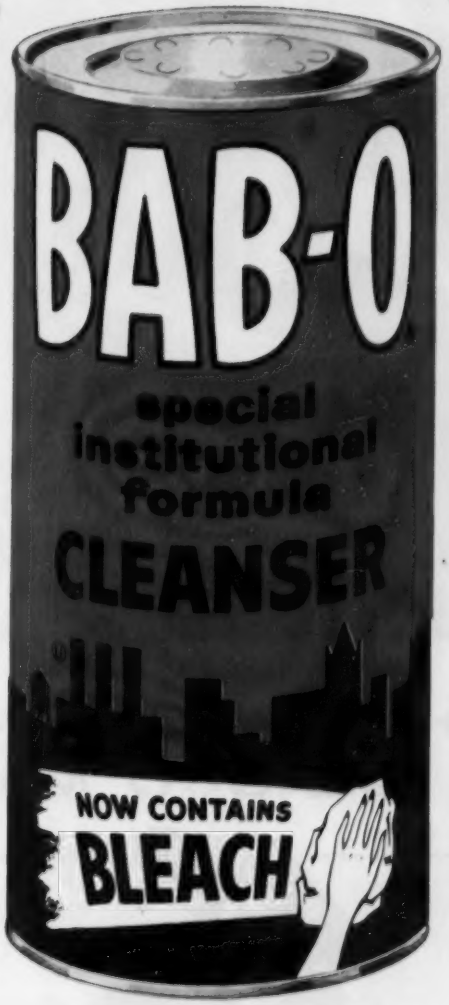
Now! **a special cleanser for hospitals...**

BAB-O with Bleach!

Cuts maintenance time and work!

ONLY CLEANSER THAT BLEACHES AS IT CLEANS

- Bleaches porcelains white as new
- Cuts grease like magic—pots and pans shine
- Safe for hands—safe for colored surfaces
- Sanitizes and deodorizes
- Has clean, pleasant fragrance
- Costs no more than ordinary cleansers

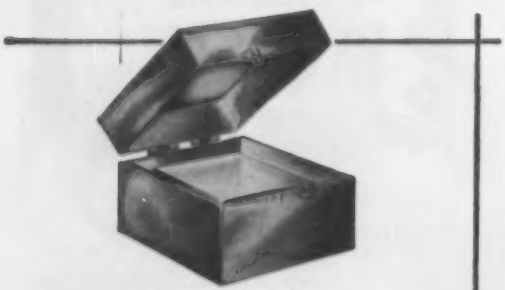


ORDER NOW Available through institutional jobbers and distributors of maintenance supplies only. Packed 24 21-oz. Giant Size Cans to the case. Also available in 100 lb. drums—shaker cans supplied *free*.

All Glasco Microscopic Slides and Cover Glasses are made of a special non-corrosive glass.

Hand selected for uniformity and perfection

GLASCO MICROSCOPIC SLIDES



GLASCO COVER GLASSES

Uniformly cut and flat on both sides, Glasco Cover Glasses are carefully made to assure high quality. They are packed in a unique plastic package that keeps the glass free from dust and moisture. You'll find many uses in the laboratory for these handy little boxes after you have used the cover glasses.

No matter what your slide preference—thick, thin, white or off-white—there is a Glasco slide available.

All Glasco slides are made from the highest quality American-made glass. They are hand selected for uniformity and perfection.

Get the best. Specify Glasco Microscopic Slides the next time you order. They are available from your hospital supply house. If you would like a *free catalog* showing the complete Glasco line and price listing, just write to the address below.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

Aid patient recovery with the new Honeywell Round!

NOW–A NEW THERMOSTAT SYSTEM

In room 204, this patient is well on her way to recovery from minor surgery. Her doctor felt that a temperature of 75° would contribute most to her sense of well-being. This is easily possible because of the Honeywell Hospital Thermostat installed right in her room.

In room 304, the patient suffered extensive skin burns, and his physician prescribed a room temperature of 67° to accelerate heat loss from the unaffected skin areas. This medical practice of prescribing temperatures is possible only with a thermostat in every room.

Individual Room Temperature Control now possible . . . room by room . . . to fit your budget

HERE'S a *simple* new thermostat system—the Honeywell Round—that can be installed in your present hospital for as little as $87.50 per room.*

Start *right away* with the Honeywell Round—have it installed in any heating "trouble spots" you may have. Then, as your budget permits, you can have it installed room by room throughout your hospital.

Installation of the Round is *easy* . . . you don't have to tear up floors or walls . . . *you don't even have to redecorate.* Tiny, simple wiring is used with a Honeywell automatic radiator valve and a miniature transformer.

Today physicians and surgeons in many modern hospitals prescribe *exactly correct* room temperatures to help speed patient recovery. But this medical practice is possible *only with a thermostat in every room.*

This is the only method that can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room.

This Honeywell Round System is especially designed for existing hospitals. But whether you're modernizing your hospital or building a new one, Honeywell has the Hospital Thermostat System to suit your particular needs.

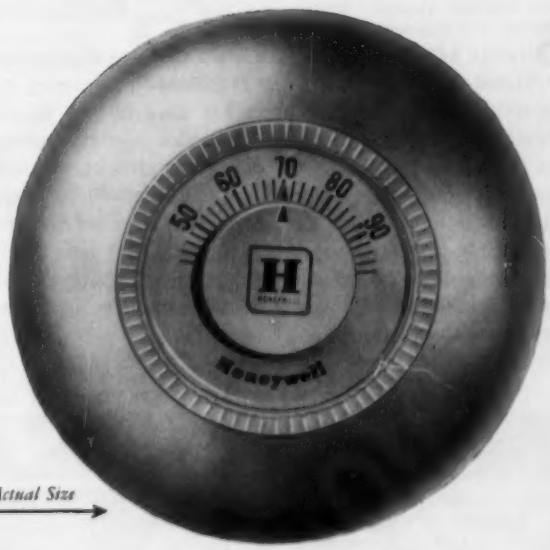
Just call your local Honeywell office for complete information. Or, write to Honeywell, Dept. MH-4-51, 351 East Ohio Street, Chicago 11, Illinois. Ask too for your copy of the new booklet "Does this happen in your hospital?"

**Average installed price for room with one radiator*

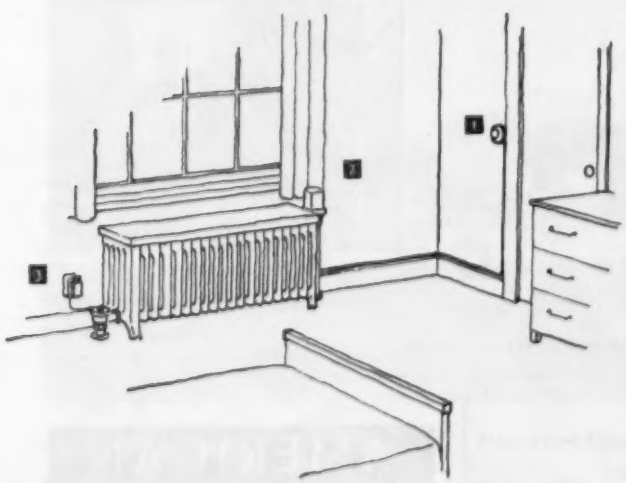
LOW-COST ROOM FOR EXISTING HOSPITALS

The new Honeywell Round features . . .

- **An easy-to-read dial.**
- **Economical installation—*no* redecorating necessary.**
- **Tamper-proof protection—settings and cover can be locked in place.**
- **Sealed, lint-proof mechanism—insures maintenance-free, dependable operation.**
- **Smart appearance—cover can be painted to blend with any color scheme.**
- **Versatility—can be used with *any* type heating system or window type cooling unit.**



Actual Size



The sketch at left shows how easily the Honeywell Round System can be installed in individual rooms in *your* hospital. The attractive thermostat **(1)** blends with the wall . . . it's connected to a Honeywell automatic radiator valve **(2)** and a miniature transformer **(3)** by a tiny wire. It's just as simple and economical as it sounds!

MINNEAPOLIS **Honeywell**

Hospital Temperature Controls

112 OFFICES ACROSS THE NATION

SMALL HOSPITAL QUESTIONS

Do We Need a Doorman?

Question: How large should a hospital be in order to justify employment of a uniformed doorman? Do you agree this is a service more hospitals should offer?—C.M.B., Mich.

ANSWER: An informal survey of opinion among several leading hospital consultants and authorities may be summed up about as follows:

The need or suitability of this kind of service depends more largely on the location and type of clientele than on the size of the hospital. Thus, many large hospitals whose patient and visitor traffic for the most part use public transportation have no need for a uniformed doorman. A much smaller hospital, on the other hand, catering to a "carriage trade," may find need for this kind of service to help patients and visitors arriving by private automobile.

Staffing Dietary Service

Question: We are a 100 bed hospital, currently making a study of our food service department, as a result of some feeling on the part of board members that our costs are too high for the kind of food service we are rendering. How many food service employes should a hospital our size have? What are the training requirements for the supervisor of this department?—J.W.R., Calif.

ANSWER: In the "Prototype Studies" of hospital organizations conducted by Dr. Louis Block of the U.S. Public Health Service, the 100 bed "prototype hospital" employed 13 or 14 persons in the dietary department. This hospital was serving from 330 to 340 meals per day; approximately two-thirds of these meals were served to patients in their rooms, the remainder being for employes, visitors and others, served in a hospital cafeteria or dining room.

Of hospitals in this size group surveyed, approximately 60 per cent employed a qualified dietitian. Four out of five hospitals in this group had mechanical, centralized dishwashing service. Four out of five hospitals had centralized tray service. One out of four of these hospitals had selective menus for patients.

Queried about the food service needs for a hospital of this size, a well known authority on hospital food service commented as follows: As to the number of persons employed in the dietary department, the answer is dependent on the type of service in the hospital. A greater number of food service workers is needed if decentralized tray service is used. The physical plant frequently influences the numbers of employes required. Purchasing procedures, such as purchase of baked goods and ready-to-cook meats, also have a bearing on the number of employes that will be needed.

The food service supervisor must be qualified to assume certain supervisory functions, such as training and supervision of new employes, preparation of employe work schedules, supervision of housekeeping in the dietary department, checking and receiving deliveries of food and supplies, preparation of orders for food supplies, instruction in the use and care of equipment, supervising food service to patients and personnel, carrying out clerical procedures, if the dietary department has no clerk assigned, visiting of patients on house diets, and contacting patients on selective menus.

Blood Bank

Question: Should a 50 bed hospital attempt to maintain a blood bank?—J.W.C., Conn.

ANSWER: In any instance, the advisability of maintaining this service would depend on the availability of blood from other sources in the area. In one recent survey of 50 bed hospitals, about half were maintaining blood banks. These hospitals issued approximately 200 units of blood per year. The average stock maintained in these hospital blood banks was approximately 10 units. The blood supply was reported as follows: 60 per cent from Red Cross blood donor centers, 34 per cent from donors in the hospital, 4 per cent from nonhospital sources, and 2 per cent obtained from other hospitals.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Should Charges Vary?

Question: What is the present practice in charging for x-ray, laboratory and other special services—do hospitals charge the same amount to all patients, or are private patients charged more than ward and semiprivate patients, for the same services?—L.P., Pa.

ANSWER: As nearly as can be determined, about 25 per cent of hospitals are now charging the same amount for service to all patients. In one group, approximately half the hospitals differentiated between private and ward patients; only a few added a further variation for semiprivate patients. In hospitals having outpatient departments, there are sometimes variable charges for outpatients and inpatients using the same diagnostic services.

To Organize Volunteers

Question: We have never had an extensive or organized volunteer service and are thinking of expanding our present program. What are the essential steps to be taken in establishing this kind of service?—P.E., Wis.

ANSWER: Before going ahead with the establishment or expansion of a volunteer program, you should be certain that definite needs exist which can be filled by volunteers, and that the idea of a volunteer service has been explained to, and accepted by, the hospital board of trustees, medical staff and, especially, employes in all departments. Also, you must be assured that enough volunteers can be recruited to maintain the services you are going to conduct in this program. Finally, some one person in the hospital should be responsible for organizing and directing the volunteer program. This person should work closely with the auxiliary or volunteer organization, planning volunteer activities, interviewing and assigning applicants, and arranging necessary training.

● *1,000,000 NEWSWEEK families* will better appreciate the Radiologist *as a physician* after reading this message in the *April 11* issue. Reprints of each advertisement in this series are available.

death took a holiday...

grandma is alive and lively! It's one of those happy facts that probably couldn't have happened a generation ago. For you see, grandma had *cancer*.

It was only 5 years ago — after one of her annual physical check-ups — that the family doctor told her what the radiologist and pathologist had detected.

Being an old-fashioned lady, grandma felt sure her time was up. Being a brave lady, she was prepared to go without fuss.

So naturally, she was surprised when the doctor said there was an excellent chance of arresting the malignancy. He thought it had been caught in time.

First came the operation. Then the radiologist attacked the cancer with a carefully planned sequence of x-ray treatments. Even an x-ray physicist worked with grandma. He helped the radiologist in plotting the treatments for best effect.

The battle was won. Grandma feels and looks fine. Death took a holiday.

First diagnosis . . . then treatment. Both depend heavily upon x-ray . . . both call for knowledge on the part of the radiologist developed through years of training and experience. To help the medical profession broaden its effectiveness, General Electric will continue to provide ever-improving x-ray apparatus.

Progress Is Our Most Important Product

GENERAL ELECTRIC

Industry, too, relies on General Electric X-Ray for non-destructive testing and inspection equipment

A NEW all-purpose Hospital Screen

featuring — a choice of colors for both frame and panels!

PRESCO Feather-Lite DE LUXE SCREEN

EXTREMELY STURDY
VIRTUALLY TIP-PROOF

We urge you to compare this new PRESCO Screen with any other, at any price. It sets new standards in design and construction and adds a touch of modern beauty wherever it is used. It is ideal where exceptional sturdiness is essential. Its design provides unusual stability without the space-consuming and sometimes hazardous pedestal-type base.

- ¾" tubular aluminum frame . . . extremely rigid and sturdy . . . anodized for lifetime service.
- 4-section model weighs only 7 pounds yet extends to six feet coverage. 3-section model weighs only 6 pounds.
- Panels of durable Goodyear Vinyl require no laundering. Easily cleaned with light germicidal solution without removing from frame. "Snap-out" curtain rods permit split-second replacement of panels. Panels available in pastel blue, rose, green or white. Also colorful circus motif for nurseries.
- 4-section model folds to 3" thickness . . . requires very little storage space when not in use.

a Variety of Color Combinations!

Standard finish for frame is satin aluminum, shown above. However, frames are also available in green, rose or gold finish, at $5.00 extra per screen. Vinyl panels are furnished in pastel blue, rose, green or white. Thus, you can effect a variety of attractive frame and panel color combinations.

PRESCO OFFERS THE MOST COMPLETE LINE OF SCREENS [illegible] FOR HOSPITAL SERVICE...

No matter what your screen requirements may be, PRESCO has either a 3 or 4-section model to fit your needs, exactly. A wide selection of colors for both Vinyl panels and frames. PRESCO'S regular Feather-Lite Screen (*shown at right*) has practically all the features of the Deluxe model described above but has ⅛" tubular aluminum frame and weighs only 4½ pounds.

PRESCO Screens are moderately priced...as low as $29.50

Order from any one of these Distributors

A. S. ALOE COMPANY
1831 Olive St., St. Louis 3, Missouri

AMERICAN HOSPITAL SUPPLY CORPORATION
2020 Ridge Ave., Evanston, Illinois

MEINECKE & COMPANY, INC.
225 Varick St., New York 14, New York

WILL ROSS, INC.
4285 North Port Washington Road
Milwaukee 12, Wisconsin

THE QUESTION

"HOW COME?—Indian Cobras in an Armstrong X-4 Baby Incubator?"

In the February issues of various hospital magazines we showed two pictures of Indian Cobras in an Armstrong X-4 Baby Incubator—and asked "How Come?" For the best answer we offered a complete, latest design, Armstrong X-4 Baby Incubator AND a $50.00 cash reward.

THE ANSWER

Some time ago we were watching "ZOO PARADE," one of the finer TV programs put on Sunday afternoons by the Lincoln Park Zoo of Chicago, under the deft guidance of Mr. Marlin Perkins, the zoo's director. Mr. Perkins was telling about the problem of caring for a sick baby monkey. Now, we like monkeys and it seemed to us that a sick baby monkey would feel just as sad in his monkey insides as a human baby, so we wrote Mr. Perkins and offered him an old second-hand Armstrong X-4 Baby Incubator for his smaller sick patients. (We had two old beaten up X-4's that had been returned to us for two new X-4's under our service exchange plan.) The answer came back that they'd like both incubators. We rewired them, gave them a mighty quick coat of "barn paint" and shipped. Mr. Marlin Perkins, his assistant Mr. J. Lear Grimmer, and the zoo's veterinarians seemed delighted—and interesting stories began to come in about how the X-4's were being used.

Late last year Mr. Perkins and Mr. Grimmer sent us some splendid pictures (you saw two of them) of the Indian Cobras that had just been hatched in one of these old X-4 Incubators. "15 eggs were deposited on the floor of her cage by our female Indian Cobra." They had some trouble hatching them—lost 5 and finally put the remaining 10 eggs in the same old X-4 Incubator, "together with the sawdust they had used so that the eggs would not change position." (Contrary to bird's eggs, reptile eggs should never be turned). 9 of the 10 eggs hatched. One youngster died when he emerged from his shell—8 survived.

Who knows, the venom from some of these Indian Cobras may one day help a physician bring health, hope, or at least more comfort to a polio or cancer victim. We ran the "contest" because we thought that you, too, might be interested in this unusual use of an old X-4 Baby Incubator.

THE WINNERS

First Prize

LEROY WINTERS HAMMETT, *Director*
Fall River General Hospital, Fall River, Mass.
1 Armstrong X-4 Baby Incubator — Plus $50 cash

Second Prize

C. M. BYRD, *Superintendent*
Dr. Rodman's Hospital, Leachville, Arkansas
$25 cash

HONORABLE MENTION

Unadvertised, unannounced (and we hope, unexpected) we have also made the following 39 honorable mention awards of $5.00 each because of the interest, sincerity, good humor or just plain friendliness expressed in the letters of these 39 individuals.

Mary Simuneh, *Huron S. Dak.*
Wilma Clare, *L.P.N. Wenatchee, Wash.*
H. K. Leslie, *Lincoln, Neb.*
Nancy L. West, *Jerome, Idaho*
Capt. B. F. Avery, USN, *Wash. D. C.*
John H. Mosely, *Montgomery, Ala.*
Shirley A. Paul, R.N., *Memphis, Tenn.*
Sr. M. Evarista, *Covington, Ky.*
Majanah Bender, *El Paso, Texas*
Helen Ishmanel, *Kiowa, Kansas*
Janet Armbrister, *Petersburg, Va.*
Sister M. Dorothy, *Mankato, Minn.*
H. L. Kayser, M. D., *Phila. Pa.*
Sister M. Dorothea, *Enid, Okla.*
Marshall G. Ause, *Milwaukee, Wisc.*
Robert E. Sleight, *Boston, Mass.*
M. Eileen Todhunter, *Boston, Mass.*
Charles A. Turner, *Lowville, N. Y.*
Frederick G. Smith, M.D., *Marion, Ohio*
Eula S. Cogley, *Youngstown, Ohio*
Joseph G. Bertolami, *Miami, Fla.*
Rae B. Elgin, *Knoxville, Iowa*
P. G. Duffy, *Stanford, Calif.*
Sr. M. Columba, *Oliver, B. C., Canada*
G. K. Palin, *Montreal, Quebec, Canada*
Marie A. Von Dollen, *Berkeley, Calif.*
Barbara Smith, *Bangor, Maine*
Edward A. Thomson, *St. Joseph, Mo.*
T. L. Francis, *De Ridder, La.*
Ann Stasch, *La Porte, Indiana*
May T. Bell, *Evanston, Illinois*
Mother Gabriel, *Chicago, Illinois*
B. W. Mandelstam, *Minneapolis, Minn.*
J. C. Grant, *Sauk Centre, Minn.*
Louis E. Swanson, *Durham, No. Car.*
Leonard Wilson, *Alberta, Canada*
Sr. Edmund Campion, *Halifax, N. S.*
Maj. Glenn M. Reynolds, *U.S.A.F., Calif.*
R. Norman Brough, *Kingsport, Tenn.*

THE GORDON ARMSTRONG COMPANY, INC.
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wire from Washington

HILL-BURTON APPROPRIATION

Surprising nearly everybody, the House appropriations committee added $10 million to the Administration's budget bureau recommendation for Hill-Burton, making it a near certainty that the appropriation for the coming year will stand at $75 million. For the expanded program the House committee recommended only $21 million, instead of the $60 million the Administration had asked for.

This was not actually the trimming it appeared to be, however, as the committee pointed out that funds appropriated for the four new types of facility this year had not been obligated. If the new program gets rolling faster than the committee expects, it was pointed out, a deficiency appropriation early next year would keep it going at high speed.

HOOVER COMMISSION

Congress seems in no rush at all to pass laws that would put the Hoover Commission's medical recommendations on the statute books. The attitude is understandable, inasmuch as most of the major suggestions are loaded with controversy. Furthermore, for all its bipartisanship, the Hoover Commission carries a Republican label that is not appealing to the Democratic Congress.

At this writing no bills have been introduced to carry out the Commission's recommendations. Some certainly will be in the next few weeks, but with Congress already struggling with a heavy load of medical legislation, it would be surprising if any of the Commission ideas got past the hearing stage before adjournment.

Regardless of its present cool reception, the medical report represents a massive amount of digging and its impact will be felt through the next few Congresses. What the commissioners said about the various federal medical and hospital programs will be recited to committees, and the report will not be ignored forever. Also of long-run importance is the report of the Commission's Medical Task Force, which the Commission accepted in part and rejected in part.

Commission and Task Force recommendations of particular significance to hospitals:

HILL-BURTON. The Task Force noted that H-B bed ratio formulas indicate the country needs about 812,000 more hospital beds, or almost eight times the number already constructed under the program. Concluded the Task Force: "A basic study of the validity of these formulas is sorely needed." The Task Force also sharply criticized the H-B leadership, and particularly the Hospital Council, for not taking U.S. beds (V.A. and military) into account when evaluating community resources. Also, the Task Force raised a number of fundamental questions about the program: Is regionalization of facilities being accomplished? Are small hospitals in rural or semirural communities unduly encouraged? Has enough thought been given to the staffing of small hospitals? Are the "proper ratios" used in estimating hospital bed needs? There are enough warning signs, the Task Force said, to call for "an objective study" by "an outside body not directly engaged in the program." It proposed that the study be made by a new Federal Council of Health, creation of which is recommended.

The Commission itself does not share all this alarm. In its report the Commission repeats some of the factual material in the Task Force summary, and some of the criticism, but dismisses Hill-Burton with this:

"This has been a useful program. It needs reappraisal today, however, particularly of such problems as the validity of bed-ratio standards, the regionalization of hospital services, and the relation of the small community hospital to the total hospital program. Such a reappraisal would be a proper function of the Federal Advisory Council of Health."

The Health Council referred to would supplant the present Health Resources Advisory Committee of the Office of Defense Mobilization and the Advisory Committee to Selective Service. The personnel of these committees is the same; the chairman is Dr. Howard Rusk. The committee also would have over-all advisory and coordinating authority for all federal health work.

VETERANS ADMINISTRATION. The Task Force came to the obvious conclusion that the question of the right to medical care for nonservice-connected conditions was the most critical issue facing V.A. The Task Force's solution would be the closing of 20 specific hospitals and the cancellation of plans for all new hospitals, and a three-year limitation (following discharge) beyond which a veteran could receive no care for nonservice-connected disabilities. Coupled with this last point, the Task Force recommended that outpatient care be authorized for nonservice cases, to reduce the unnecessary patient load in hospitals.

The Commission went along with the Task Force recommendation on cutting down on hospitals. Then it adopted the suggestion for outpatient care, but for some reason rejected the three-year cutoff, which was directly tied in with the outpatient care proposal. The Task Force idea was arbitrarily to restrict nonservice care to the first three years after discharge, then to keep some of these patients out of hospitals by giving them outpatient care. If the Commission's recommendations were implemented, some critics charged, the result would be more rather than less care for nonservice cases.

The American Legion immediately attacked the Commission's recommendations for cutting down on V.A. hospitals, but not before the American Medical Association had objected to the authorization of outpatient care without the three-year deadline. So on this the Commission found itself in the middle.

MILITARY HOSPITALS. Both Task Force and Commission agreed on recommending a "regionalization" of military medical services. Under this system the country would be broken into regions, with the particular service with

preponderant medical responsibilities in the area put in over-all charge. This would bring about a certain amount of unification, but nothing like the unification proposed by the first Hoover Commission, whose idea was to unify all federal hospitals—V.A., military and Public Health Service.

MEDICAL-HOSPITAL CARE SUPPLIED BY U.S. Both Task Force and Commission said merchant seamen should no longer be considered a responsibility of the federal government and that their free medical care should cease. Both would have the U.S. set up contributory health insurance for such classes as Public Health Service, and Coast Guard and Coast and Geodetic Survey, and for the dependents of military personnel, with the U.S. bearing a high proportion of the cost. Both also proposed health insurance for U.S. civilian employes, but with the U.S. contribution on a lower scale. With most P.H.S. patients thus taken care of, the Commission proposed cutting off the P.H.S. general hospital and medical care programs immediately, but the Task Force didn't go that far.

IN GENERAL. Commission and Task Force agreed that there should be more cross-servicing of patients, a freer exchange of professional personnel, and that the Federal Hospital Council should have to approve any new hospital construction.

U.S. HOSPITAL CRITICISM. Waste of hospitals and inefficient use of manpower were cited by the Task Force in Veterans Administration and military hospitals. The Commission did not challenge these facts, and underscored many of them. Specifically, it was found that 60 per cent of the Defense Department beds were unused in the San Francisco area, the same percentage in the New York area, and 50 per cent in the Norfolk, Va., area. As evidence of the lack of cross-servicing, on the average day in 1943 there were 52,760 unused military beds, while the average cross-servicing of patients amounted to only 2255 beds per day. "Since 1952," the Task Force report says, "the number of unused beds in military and Veterans Administration hospitals increased from 60,000 to 77,000. Construction now in progress is likely to increase the unused beds by another 10,000."

The Task Force also resurrected the same facts that had aroused the first Hoover Medical Task Force six years ago. The average military man spends eight days a year in a hospital, whereas the average civilian spends one day. The Task Force concludes that "patients tend to linger in military hospitals. . . . The amount of hospitalization given to military personnel seems excessive in terms of good medical care."

The Task Force mentions casually that 42,000 births occurred in military hospitals in 1948, but that by 1953 military hospital maternity cases had reached 145,000. Incidentally, the Task Force proposes ending the doctor draft act at the scheduled expiration date of next July 1, but the Commission merely wants the question studied.

OTHER RECOMMENDATIONS OF COMMISSION. The haphazard, wasteful and duplicating systems of medical supply procurement should be unified, but complete recommendations will be made by a separate Task Force on Supply. The Federal Health Council would stimulate medical research, and the provision of more preventive health services, particularly for military dependents and Public Health Service dependents. The President is urged to review present systems for the recruitment, training and utilization of professional health personnel.

MEDICAL SCHOOL AID

House and Senate committees have indicated that, after mental health, the next subjects to be considered will be legislation for grants to medical schools, hospitals and laboratories for building research facilities, and bills for federal financial assistance to medical schools.

Both proposals have the support of the two men on Capitol Hill most important in health legislation, Chairman Percy Priest of the House interstate and foreign commerce and Chairman Lister Hill of the Senate labor and welfare committee. At the very least, it now appears that some bill on each of these subjects will be voted out of both committees

The idea for research grants has wide appeal; there are few medical schools or large hospitals that would not welcome new facilities that could be designated as research, provided the federal government paid a large share of the cost. Under the bill the facilities would have to be devoted to research on one or more of 10 general conditions: cancer, heart disease, poliomyelitis, nervous disorders, mental illness, arthritis, rheumatism, blindness, cerebral palsy, and muscular dystrophy.

Leaders in mental health work are particularly enthusiastic over this legislation. They think it might at least double the amount of research going on in institutions.

Senator Hill's bill—it is supported in the House by Priest—appears to be attracting the most attention of all bills on medical education. It would set up a five-year, $250 million program of grants. New schools could get two-thirds of the construction cost, but existing schools would be held to half the cost of expansion unless they agreed to increase freshman enrollment by 5 per cent, in which case they would qualify for two-thirds.

Evidence of what is happening in Congress is the fact that neither the Hill nor the Priest committee is in any rush to look into the two bills described by Secretary Hobby as the most important on the Administration program—reinsurance and federal guarantee of mortgages for health facilities.

NOTES

Senator Hill, with the help of a joint American Hospital Association-Blue Cross committee, is attempting to work up his own bill on grants for medical care of three groups: the aged, the indigent, and the unemployed. As under an Administration bill, the money would be handled by the states, but the Eisenhower bill is limited to helping the indigent only. Whether or not the Hill measure is passed, its introduction probably means that the Administration bill won't be considered.

Val Peterson, federal civil defense administrator, has been asked by A.H.A. to disclose more facts on the medical aspects of nuclear explosions so the hospitals can be prepared to meet their responsibilities. The hospitals also want to know what kind of leadership the federal government will supply, and what degree of coordination they can expect from Washington. The questions were put to Mr. Peterson following release of information on the extent of the lethal fall-out from hydrogen bombs.

To help along its campaign for 5000 more Public Health Service reserve officers by July of 1956, P.H.S. is conducting a series of two-week courses in Washington to acquaint health personnel with the problems it would face in case of atomic or hydrogen attack. The first course was attended by 50, physicians, dentists, nurses and public health specialists.

The Modern Hospital
APRIL 1955

LOOKING AROUND

Colorful Era

THE increasing use of color has been one of the exciting developments in recent hospital practice. Psychologists have long recognized that different colors produce different emotional responses; now medical research suggests that color may actually affect physiologic function. Thus the use of color in hospitals may be expected to grow, as more and more is learned about its effects on hospital patients.

In addition, proper selection of colors in work areas may speed performance and diminish fatigue among workers, help control traffic in congested corridors, reduce accident hazards, and generally improve hospital efficiency. These and other uses of color in the hospital are described by one of the nation's foremost color consultants in the special article on page 65 of this issue.

The only way to report color is to use color. Beginning this month, therefore, The MODERN HOSPITAL is introducing a new service in hospital journalism, a front cover designed to permit a fresh report each month showing what hospitals are accomplishing with color. The new cover will feature full-color reproductions of buildings, patients' rooms, service departments, and hospital activities in which color now plays an important part.

To bring this new service to our readers, we had to discontinue a tradition that has lasted through 42 publishing years—the front cover featuring "Modern Hospital yellow." This color appeared on the original MODERN HOSPITAL cover in 1913 and was retained, through a series of design modifications, up to last month. It has been dropped now only to make way for a design which permits us to do better our everlasting task of reporting all that is happening in hospitals today.

We hope there will be some long-time MODERN HOSPITAL readers who will share our regret that a tradition has come to an end, and many to share our pride in the new cover which will help us do a better reporting job in this colorful era.

Branch Water

THE Commission on Organization of the Executive Branch of the Government, or Hoover Commission, has floated a new set of recommendations aimed at eliminating waste and duplication in the federal medical services. This time, the chief recommendations would:

1. Tighten eligibility rules for care of nonservice-connected disabilities in Veterans Administration hospitals.
2. Dispose of V.A. hospitals which aren't operating effectively.
3. Coordinate the medical and hospital services of the armed forces within specified geographic areas.
4. Close general hospitals and clinics run by the U. S. Public Health Service.
5. Establish a Federal Advisory Health Council to further coordination, prevent duplication, and develop over-all policies in the medical services.

Actually, the commission's recommendations represent a drastically watered-down version of the proposals made by its own Medical Services Task Force. With Dr. Edwin L. Crosby of the American Hospital Association as director of study, that group had boldly suggested eliminating all care of nonservice-connected disabilities after three years, closing 19 V.A. hospitals it said were "poorly located, uneconomic and inefficient," and eliminating certain military hospitals as well.

What happened to the Task Force proposals, in all likelihood, will now happen to the commission recommendations. Already, the gored-ox chorus is tuning up. The American Legion let loose an anguished bellow about closing V.A. hospitals and cutting down on care of nonservice-connected disabilities, and Speaker Sam Rayburn of the U.S. House of Representatives has protested the proposal to shut down a veterans facility in Bonham, Texas. Mr. Rayburn, it turns out, lives in Bonham, Texas.

The trouble with the Commission on Organization of the Executive Branch of the Government and, just possibly, the trouble with the government, is that there is always somebody from Bonham, Texas, who is in a position to influence recommendations affecting Bonham, Texas. The reason government agencies get bigger is that it always costs somebody votes or jobs to make them smaller; expecting a government agency to cut down size and waste is like asking a surgeon to amputate his own hand.

This kind of trouble was foreseen,

more than a hundred years ago, by the British political philosopher John Stuart Mill. "One of the greatest dangers of democracy lies in the sinister interest of the holders of power," he wrote, "and one of the most important questions demanding consideration, in determining the best constitution of a representative government, is how to provide efficacious securities against this evil."

The best security we have provided in the United States is our well known system of checks and balances operating among the legislative, executive and judicial branches of the government. But the checks and balances don't always work the way they should. Sometimes, it develops, the government keeps on writing the checks, and the taxpayers pay the balance.

Crazy

IT'S John Gorby's story, and it could happen only in California: The rule was simple and understandable. "All new employes shall be escorted to the Personnel Office if they enter main lobby." You couldn't quarrel with that. Nobody wants the help cluttering up the deep leather chairs of a reception area. But the rule did not take into account Señora Carrizo, the wife of a prominent Mexican politico who could buy and sell the hospital several times over.

Señora Carrizo needed some surgery. The obvious place to enter, she thought, was the front door. She was greeted brightly by the sweet young thing at the reception desk. The señora stated her case very nicely in plain, understandable Spanish. The interchange continued for several minutes, neither side making an impression. The receptionist hesitated. This might be a patient, but also it might be a new employe. The administrator might happen along and discover one of his pet rules disobeyed. So, in deference to rules, the señora was escorted to Personnel.

No good personnel clerk wants to be faced with problems. Remembering that the laundry was short of help and had many Mexican workers, this one escorted Señora Carrizo to the laundry, where she was taken to the shake table, pending the arrival of the laundry manager. In an hour or so he arrived, and soon afterward things were restored to an even keel.

The good señora's belief that most Americans are a little crazy was not shaken in the slightest by the episode. "Only in America," she said, "do you wait for your doctor in the laundry instead of in bed."

What's in a Name?

AN ANNOUNCEMENT from St. Francis Hospital, Pittsburgh, tells us that the name of the hospital has been changed to "St. Francis General Hospital and Rehabilitation Institute." The change was made, it is explained, in an effort to create a better understanding and greater appreciation of the hospital's work. St. Francis has pioneered in the field of industrial and physical medicine and is now planning widespread expansion of its rehabilitation service.

We can understand the hospital's wish to have its functions fully understood, and we applaud the broad concept of service to the community that includes rehabilitation as well as lifesaving. We'd like to think, however, that the change in name wasn't really necessary. Before long, we hope, the concept "hospital" will comprehend rehabilitation just as surely as it now includes so many other services that didn't exist through most of the centuries the word has been used.

Good Old Days

HOSPITALS with interns represent a small proportion of all hospitals in the country, according to an editorial in the *Journal of the American Medical Association*. "It can be seen, therefore, that the number of students graduating annually is not sufficient to supply interns for all the hospitals seeking them, far less to meet the demand if all general hospitals should desire to use them," the *Journal* points out. "It can readily be seen that sufficient interns could not be provided for all hospitals even if the annual number of graduates exceeded by several times the normal output for this country.

"Many hospitals, even now, are employing physicians as residents or house officers at increasing salaries or with generally increasing privileges in the way of practice. Interns, also, should be relieved of much of the work required of them which should be done by orderlies employed for that purpose. History-writing and records, which have depended largely on intern service, can be kept up by staff physicians through the use of stenographers. It is certain that the increased demand for interns does not justify either the lowering of educational standards or a multiplication of medical schools."

This editorial appeared in the *Journal* for Aug. 1, 1920, and is quoted by the A.M.A.'s ad hoc committee on internships, whose report is now being studied by the Council on Medical Education and Hospitals. Hospital administrators and physicians struggling with intern problems may be cheered or depressed, according to their natures, by this evidence that the problems remain essentially unchanged after 35 years. Our own view is that hospitals had it pretty good back in those days: Apparently, you could get orderlies and stenographers then.

Kill the Coroner

THE Institute of Medicine of Chicago, as conservative a group as you are likely to find in a profession that isn't exactly radical, has called the coroner system "a travesty on public safety and criminal justice." The Institute's choler was aroused by a case in which the coroner, a layman and a politician, sought to determine medical facts in a case having widespread public interest. In jurisdictions where the antiquated coroner's system still persists, this happens right along.

Wherever possible, hospital people should join hands with physicians in the effort to replace coroners with medical examiners. Where, as in Chicago, the existing system has its roots in the state constitution and can be abolished only by referendum, hospital and medical groups should push legislation aimed at bringing the coroner's office in line with modern practice. Appropriate legislation, according to the Institute, will provide for more efficient investigation of unexplained or violent deaths, postmortem examinations by specially trained physicians, abolition of the inquest, and assignment of the legal phases of such cases to the state's attorney's office.

How Free Are Our Hospitals?

The hospital still controls its own economic destiny, this survey shows, but signs are appearing that rates, tax exemption, and independent action may be challenged

F. GORDON DAVIS
Birmingham, Mich.

THE interest of public officials in hospital costs and charges is growing, according to a recent nationwide survey, and the nonprofit status of hospitals is being questioned—in some cases by authorities who are in a position to challenge the hospital's tax exemption.

These are not yet trends, the survey indicated. The reported episodes, rather, are simply warning signals that may foretell trends. As such, they raise some questions that hospital administrators and trustees should be asking themselves today:

Are our hospitals really as free as we think? How great is the hospital's power of self-government? Is there evidence that outside forces are beginning to interfere with its operation?

Most hospital administrators are not particularly disturbed by such queries so long as the questions remain in the present tense. It is obvious that the destiny of our voluntary hospitals is still largely in their own hands.

NOT WHETHER BUT WHEN

But the future is another matter. The trend of our society is toward increasing regulation of its components, and those who take the long view doubt seriously that hospitals will be exempted from the effects of this trend. The question is not so much whether government will increase its controls over the hospital, but when, in what manner, and to what extent.

To shed light on this important problem, The MODERN HOSPITAL queried hospital spokesmen and leaders from coast to coast. The results, as summarized in the table on pages 52 and 53, may well give serious pause to all thoughtful hospital authorities. Briefly, they show:

1. That the insurance officials of at least nine states deem hospital charges or costs their proper concern.

2. That there has been active questioning of the nonprofit status of the hospitals in 18 or more states.

3. That governmental interest in hospital operations is definitely expanding in 21 or more states.

The interest of insurance authorities in hospital costs stems from Blue Cross economics. When Blue Cross rates increase, the burden of approving these unpopular adjustments falls in some states on the insurance officials. Their approval is not likely to endear them to the voters. To relieve the pressures on themselves, the insurance officials want proof not only that hospital costs are what Blue Cross says they are, but that the costs are "reasonable" and fully justified. Thus do the hospitals collide with the hard facts of politics.

Some of our most eminent hospital spokesmen openly admit pessimism in this connection. Hospital costs at present are not subject to control either by the law of supply and demand, as is the case with competitive products and services, or by governmental regulation, as is the case with enfranchised public utilities. The public is becoming aware of this circumstance, but public ignorance of the elements that enter into hospital costs is profound and the hospitals are doing little to relieve it. Public suspicion is a natural consequence.

With due respect for the sincerity of insurance officials, most hospital people do not believe that hospital costs are an insurance concern any more than are the repair costs of a damaged automobile which is covered by collision insurance. The fact remains that insurance officials feel compelled to move in on the hospitals. In nine states they have indicated that they have either moral or statutory obligations requiring their interest in hospital costs.

Ohio has been one state in which developments of this nature are well advanced. Public furor over increases in Blue Cross rates during 1953 resulted in legislation broadening the authority of the superintendent of insurance, giving him the power to determine whether Blue Cross rate requests are "reasonable" and enabling him to call public hearings on changes on Blue Cross rates.

HEARINGS IN OHIO

Within recent months there have been four public hearings on rate applications submitted by different Ohio Blue Cross plans. The testimony at the hearings became front page news throughout the state. Ohio's leading newspapers investigated both Blue Cross and hospital costs. Radio and television joined in adding to the public clamor. The result is a general attitude toward the Blue Cross-hospital rate problem in Ohio that is indistinguishable from the attitude commonly manifested toward public utility rate matters.

In Michigan there has been keen interest in hospital costs on the part of the insurance department. A Michigan survey of hospital costs was

(*Continued on Page* 54)

IS GOVERNMENT INCREASING ITS CONTROLS OVER HOSPITALS?

—Results of a National Survey—

THE QUESTIONS:

1. Have the insurance authorities in your state attempted to establish jurisdiction over hospital charges to patients with Blue Cross or other insurance protection?
2. Have elected or appointed officials in your city, county, township or state publicly or privately questioned the nonprofit or tax exempt status of your hospitals?
3. Have you encountered evidence of growing governmental interest in internal hospital affairs and operations?

THE ANSWERS:

HOSPITALS	CONTROL OF CHARGES	NON-PROFIT STATUS	GOV'T INTEREST	REMARKS
Alabama	No	Yes	No	Tax exemptions questioned.
Arizona	Yes	No	No	Some discussion of nonprofit status. Hospitals pay sales tax. 1953 case started by insurance company sought to force hospitals to charge public rates to Blue Cross patients.
Arkansas	No	No	No	
California	No	Yes	Yes	1953 statute limits surplus to 10% of operating expense in any year. State board held in 1954 that one hospital's payments to pathologist are excessive, raising question about tax exemption. Government interest increasing largely because hospitals have asked government support in various ways.
Colorado	No	No	No	
Connecticut	No	No	No	Seeking budget reductions, governor proposed to discontinue state grants to hospitals. Law states hospital is nonprofit and thus tax exempt only if it receives state grant.
Florida	No	No	No	Osteopaths, chiropractors, naturopaths have questioned nonprofit status of hospitals. Also some criticism of self-perpetuating boards.
Georgia	No	No	No	
Idaho	Yes	No	No	1953 bill to regulate medical and hospital service plans would have provided that fees to hospitals, physicians "shall be reasonable."
Illinois	No	Yes	Yes	Questioning of nonprofit status by public officials largely result of lack of knowledge. Illinois Hospital Association helped 1953 licensing law. Attempts to lift tax exemption based on racial discrimination.
Indiana	No	Yes	Yes	Tax exemption questioned by local officials apparently as bargaining measure in setting rates for indigent. Interest in internal operation of hospitals chiefly result of interest in lower rates for public cases.
Iowa	Yes	No	Yes	Insurance superintendent believes Blue Cross is overcharged by some hospitals, subject to excessive utilization. Public interest in internal affairs stems from hospital-medical specialist controversy.
Kansas	No	No	No	
Kentucky	....	....	No	
Louisiana	No	No	No	Legislature heard charge that hospital rates are unreasonably high during discussion of broadening Workmen's Compensation benefits.
Maine	No	No	No	Some private complaints by city authorities on tax losses resulting from hospital exemptions.
Maryland, Dist. of Columbia, Delaware	No	No	No	
Massachusetts	....	....	Yes	
Michigan	Yes	Yes	Yes	Insurance authorities definitely interested in hospital charges but have not sought jurisdiction. Criticism of nonprofit status of hospitals is heard in legislature.
Minnesota	No	Yes	No	Legislative committee checked nonprofit status of hospitals several years ago, reported that hospitals are definitely nonprofit.

NOTE: This tabulation represents the best judgment of the analyst as to the intent of the respondents, most of whom replied to The MODERN HOSPITAL questionnaire with general statements rather than direct answers. In some cases there were several respondents from the same area, and their answers were not always in agreement. These differences were resolved by weighing the specific evidence submitted on both sides.

THE ANSWERS:

HOSPITALS	CONTROL OF CHARGES	NON-PROFIT STATUS	GOV'T INTEREST	REMARKS
Mississippi	No	Yes	Yes	Last legislature got bill to exclude hospitals from sales tax exemption. Most government interest is from agencies reimbursing hospitals. State Department of Audit has criticized Blue Cross reimbursement formula as it applies to county hospitals.
Missouri	No	Yes	Yes	Some private legislative questioning of tax exemptions. Government mostly sympathetic.
Montana	No	No	No	
Nebraska	No	No	No	
New Hampshire	....	No	Yes	New Hampshire welfare commissioner has publicly criticized hospital charges for care of indigent.
New Jersey	....	....	Yes	Considerable public interest in hospital costs. One former state official advocated control of hospital costs.
New Mexico	No	Yes	Yes	Government interest mostly local.
New York	Limited	Yes	Yes	Considerable activity having to do with payment for public cases. Insurance Department requires Blue Cross to pay hospitals on basis of either costs or public charges, whichever is the lesser.
North Carolina	No	No	No	
North Dakota	No	Yes	Yes	Increasing government interest in hospital tax exemptions and hospital operations.
Ohio	Yes	Yes	Yes	
Oklahoma	No	....	No	
Oregon	....	Yes	....	State tax authorities interested in hospital exemptions. Tax exemption in one instance granted only under requirement that hospital reject no admissions for inability to pay and refuse staff privileges to no "qualified" physicians.
Pennsylvania	Yes	No	Yes	Government interest held to be minimum in view of size of government payments to hospitals.
Rhode Island	No	No	No	
South Carolina	No	No	No	
South Dakota	No	Yes	Yes	Loss of tax exemptions threatened but averted. State officials sympathetic to hospitals.
Tennessee	No	....	Yes	Hospitals work closely with State Department of Health.
Texas	No	Yes	Yes	Some cities have attacked tax exemptions of some hospitals. Court case pending.
Utah	No	No	No	
Vermont	No	No	No	
Virginia	Yes	Yes	No	Law recently amended to assure tax exemptions.
Washington	No	No	Yes	Government interest results largely from licensing, payment for public cases.
West Virginia	Yes	Yes	Yes	State tax department is seeking to impose sales tax on some hospitals.
Wisconsin	No	No	Yes	
Wyoming	No	Yes	No	County assessors questioned tax exemptions, but did not press.

TABULATION OF RESULTS

Question 1: Insurance authority jurisdiction over hospital charges:

No	32
Yes	9
No Ans.	5

Question 2: Nonprofit status questioned:

No	23
Yes	18
No Ans.	5

Question 3: Increasing government interest:

No	24
Yes	21
No Ans.	1

(*Continued from Page* 51)
undertaken as a direct result of a suggestion from the insurance commissioner, and there has been other recognition of the relationship between Blue Cross rates and hospital costs.

The nonprofit status of the hospitals has come under fire for similarly "political" reasons, which is to say that both elected and appointed representatives of government are sensitive to popular impressions and pressures. Recent public opinion studies have shown that large segments of the population—a majority of those holding opinions, in some areas—do not believe that the hospitals are nonprofit.

For this reason the public may be receptive to suggestions that hospitals should be taxed and may commend rather than deplore the public officials who propose this expedient. To the same attitude may be charged the almost universal efforts of representatives of local government to negotiate rates for the care of public assistance patients as they would negotiate for services from a commercial rather than a nonprofit agency.

From the broad point of view it is unquestionably true that the hospitals themselves have done a great deal to invite governmental interest, and much of this has been good. They have backed the Hill-Burton program and have benefited greatly from its operation. As private philanthropy has dwindled, the hospitals have turned more and more to government for reimbursement for charity expenses, and indeed they are generally insisting that the total welfare of the indigent is a basic governmental responsibility. Furthermore, the hospitals have asked the assistance of government in their efforts to realize self-improvement through licensure and the establishment of sound institutional and professional standards.

Few could claim that there is not an area for a natural and productive partnership between the hospitals and government. Few would maintain that the responsibilities of this partnership should not be divided between both parties, with the hospitals accepting their just share in return for governmental aid and support.

The problem is that which concerned Jefferson and Lincoln — the problem of allocating to government those functions which it can perform best while retaining the utmost in individual and local freedom and responsibility. And this problem can never be resolved permanently. In the familiar words of John Philpott Curran, the Eighteenth Century Irish judge and orator, "It is the common fate of the indolent to see their rights become a prey of the active. The condition upon which God hath given liberty to man is eternal vigilance. . . ."

Where, then, must the hospitals exert this vigilance? Analysis of the replies to The MODERN HOSPITAL'S questionnaire gives a direct clue. Where hospital relationships with government have reached a state of tension or dispute, the issues are invariably economic. Hospital costs as reflected in Blue Cross rates, hospital reimbursement for care of public assistance patients, efforts to tax hospitals, even the jurisdictional argument which is taking hospitals and medical specialists into the courts as opposing litigants—all these are enveloped to a greater or lesser extent by the long shadow of the dollar sign.

The trends indicated by the survey are not yet sweeping, but their direction is clear. If there are states which they have not touched, there also are states in which their intensity is unmistakable.

Will there be public regulation of hospital costs? Will it be intelligent regulation evolving under sound patterns shaped largely by the hospitals themselves? Or will it arrive through the back door, influenced primarily by political considerations?

Answering these questions is certain to become a serious mission for the leaders of our hospitals. The problem is diverse, as shown by the survey. It is in great need of group study and action. It also places a further premium upon the vision and resourcefulness of individual hospital administrators. So far as their own hospitals are concerned their future freedom of action may depend chiefly on their personal understanding and control of the economics of their institution, and on their ability to interpret the hospital's economic operations to government and to the community.

Critics Question F.H.A.-Type Financing of Hospital Construction as Proposed in Administration Bill

WASHINGTON, D.C.—Some hospital authorities are apprehensive about implications of the administration's proposal to encourage mortgage financing of medical facilities, it was reported here last month. The Administration bill would provide mortgage insurance, similar to that furnished under the Federal Housing Administration, for loans financing construction of hospitals, clinics and other medical facilities.

While nonprofit hospitals have occasionally made business loans to finance construction, it is acknowledged, the suitability of encouraging this kind of financing for nonprofit organizations is being questioned. For example, in the case of general hospitals, it is pointed out that the interest charge per bed could add as much as $2 per day to the average charge to patients, if interest were paid out of current income. Such finance charges would also have to be considered in the premiums of subscription rates in prepayment plans.

Hospitals have raised nearly all their construction funds in the past either from private gifts or governmental grants, it was explained. "They could continue to pay off government insured loans with private gifts," one economist stated, "provided they could obtain the gifts. Paying off a debt, however, is not an effective basis of appeal for philanthropic aid."

In the effort to find a method of financing medical facilities which would enlist private business support and avoid heavy demands on federal resources, sponsors of the Administration's proposal may not have given enough consideration to its effects on nonprofit agencies or the patients they serve, this economist added.

"If the policy of financing construction costs by business loans were widespread, the effect would further raise hospital costs and deteriorate hospital public relations," he said. "Do we want more of the commercial principle and less of the service principle in our nonprofit institutions? Do we thus risk their tax exempt status?

"The Administration's bill would also permit insurance of loans to proprietary institutions. With a few exceptions, these institutions have a poor

(*Continued on Page* 160)

Confronted with the problem of planning for a modern hospital while still making the best use of its existing buildings

THE MODERN HOSPITAL OF THE MONTH

Jefferson Bridged the Gap With Bridges

HAYWARD R. HAMRICK, M.D.
Medical Director
Jefferson Medical College Hospital, Philadelphia

FOR more than a decade the Jefferson Medical College Hospital of Philadelphia had faced the twin problems of substantially increasing bed capacity and modernizing and concentrating large technical facilities.

Trustees, staff and administration saw the need for conserving and utilizing the existing buildings, with their substantial investment and resources, and yet planning for a new hospital to be as advanced as the "hospital of tomorrow."

The new hospital pavilion, a 14 story $7,500,000 building, adjoining the previous hospitals and occupying the remainder of the block, answers Jefferson's most pressing problems and provides a great new addition to the area's medical and teaching resources.

The building adds nearly 300 beds, mainly semiprivate, to the 800 Jefferson beds at the central location, and with the 300 beds in Jefferson's two chest disease hospitals brings the total complement to 1400. This will permit the admission of some 8500 more patients annually, or a total of approximately 30,000, to eliminate the long waiting list that has existed since the war.

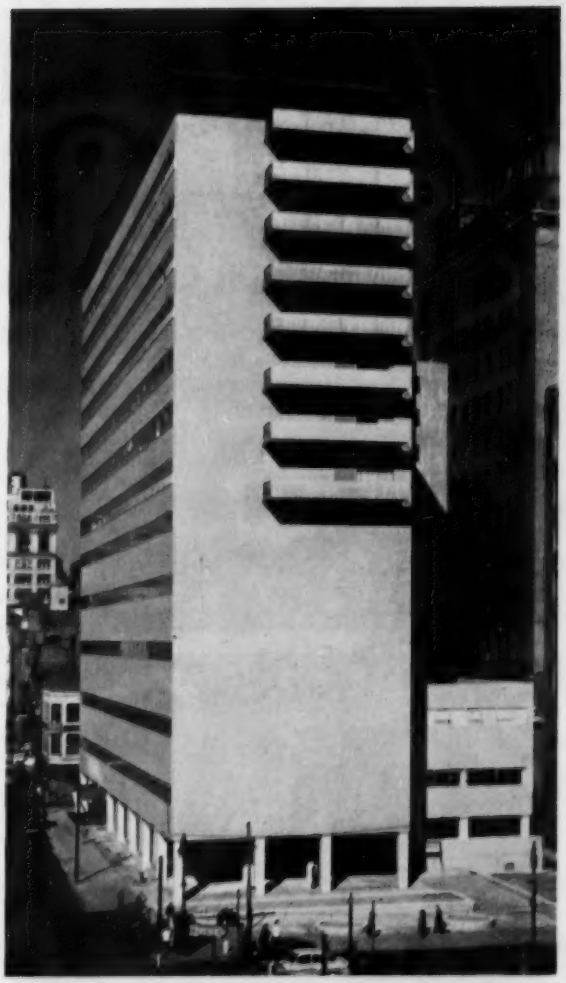
Equally important, the six floors of new technical facilities joined, as are the upper floors, to the older adjacent buildings, will concentrate these ancillary functions for all 1400 beds of the hospital.

Until the new pavilion was utilized, Jefferson's operating rooms were located over various floors of three older buildings, as were other technical departments. Equipment was serviceable but various modern conveniences were lacking.

In contrast, the ultra-modern building today has the latest and finest operating, x-ray and other technical equipment, some of it designed especially for the new structure, as will be seen in the accompanying statement by the architect starting on page 56.

Vacated areas in the older hospital buildings will be utilized for modernized classrooms and demonstration rooms, quiet rooms, postoperative recovery rooms immediately adjoining surgery floors, and a unit for psychiatric inpatients.

These expanded and modernized buildings not only will enable Jefferson to serve the region better, but will provide advanced facilities for other community hospitals affiliated with Jefferson in this institution's medical center.



Connected by bridges on each of 12 floors, the new unit of Jefferson Medical College Hospital rises 14 stories and provides 300 beds and facilities for 10 departments.

Architect's comments on

Departures in Design

at Jefferson Hospital

VINCENT G. KLING
Architect, Philadelphia

Aerial view of Jefferson Medical College Hospital.

THE most significant departures attendant upon satisfying the advances in medical philosophy and physical improvement to the entire Jefferson campus are as follows:

1. The building comprising 254,500 square feet in area, 14 stories above the street, and two stories below the street, enjoys the highest rating in Class A fireproof construction (fireproof steel and reinforced concrete).

2. The facilities in the new building have been planned to tie in functionally by floor with the existing hospital.

3. Dual electric service has been brought into a new power center in the subbasement of the building, the capacity of which is adequate to service the entire block which is now occupied by the Jefferson Hospital.

4. The interior of the building has been conceived more in the spirit of an attractive hotel than in the usual atmosphere of clinical severity. Wide, well lighted corridors with flat soft colors and wall finishes in nonglazed tile are in evidence throughout the buildings. Room and office colors, as well as draperies and furniture, have been planned to be bright and restful without being "Hollywood."

5. All ceilings throughout the building are surfaced with acoustical sound absorbing plaster and all heavy-use areas have rubber tile floors. All lighting fixtures are flush in-built for attractive appearance and easy maintenance.

6. An unusual plan for handling vertical transportation has been devised in order to prevent inpatients' traffic from mingling indiscriminately with visitor traffic. A central elevator bank which houses four high-speed electronically controlled elevators is flanked by two elevator lobbies on opposite sides of the elevator system. One lobby is for visitors and is serviced by separate cabs for them and the other lobby is for patients who are being moved to surgery, x-ray, laboratory and so on. There will be no need for visitors to ride in the same elevators or use the same elevator lobbies as do the patients who are being wheeled to and from surgical or technical areas.

7. Every known precaution for safety for both patient and hospital employe has been incorporated in the new Jefferson.

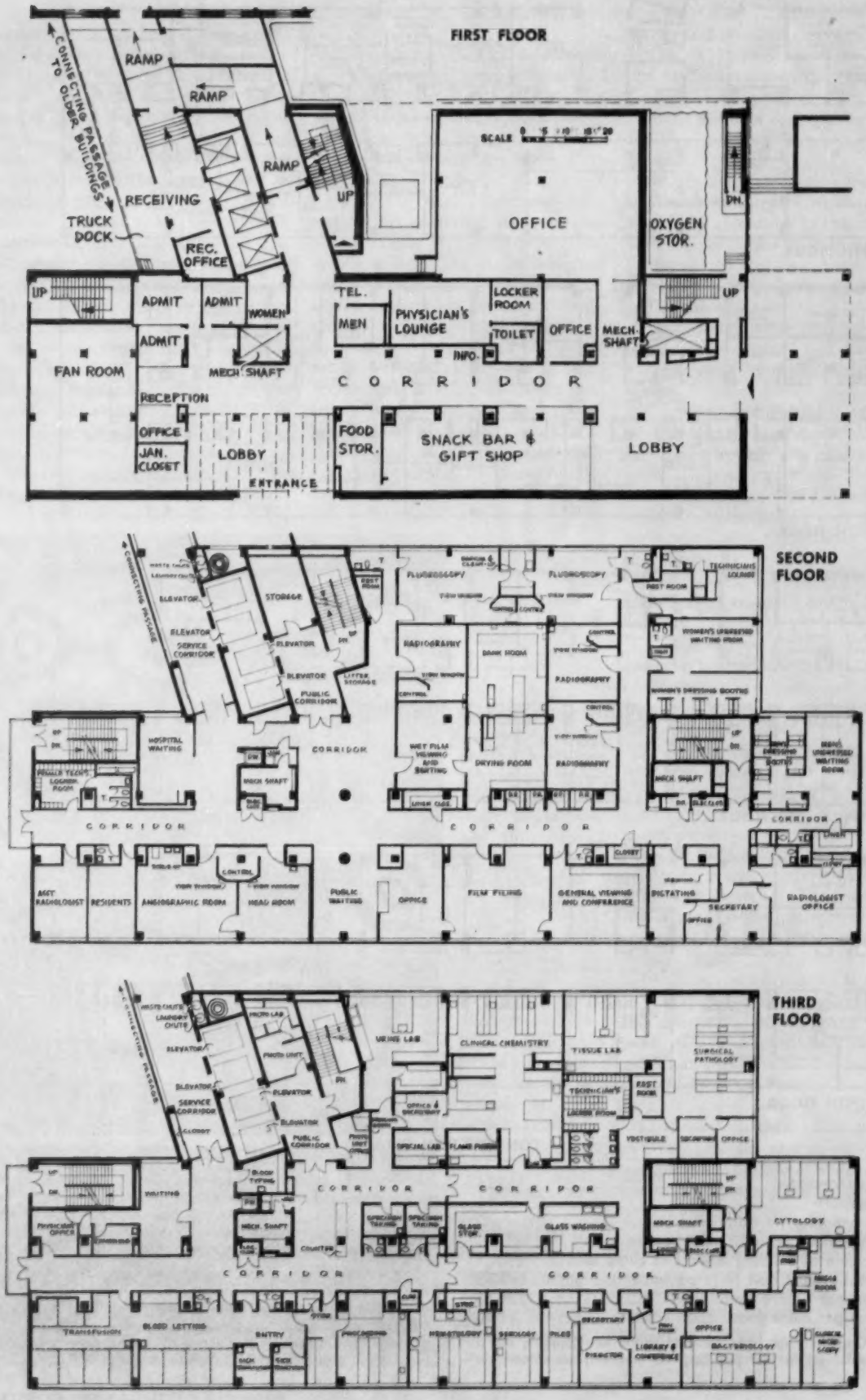
Two emergency fire towers run the full height of the building.

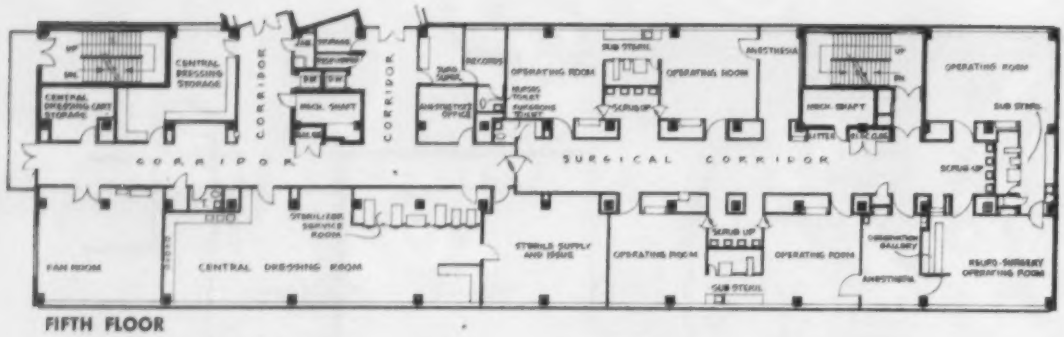
The hospital's own fire fighting

(*Continued on Page* 59)

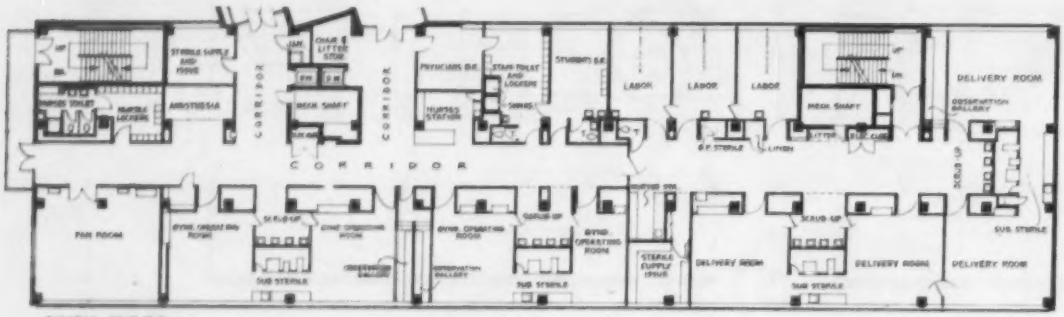
One of the two first floor lobby seating areas of the new pavilion, showing use of modern furniture.

Typical double bedroom in the new unit. Cubicle curtains separating the beds operate on a track.

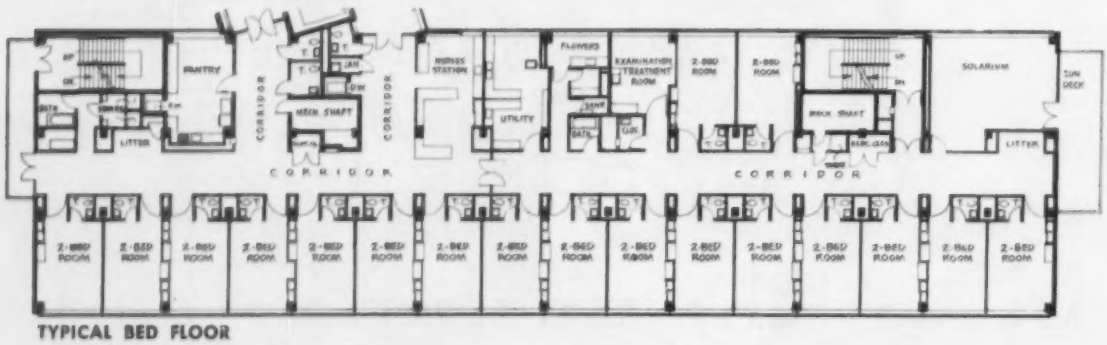

FIRST FLOOR
CONNECTING PASSAGE TO OLDER BUILDINGS
RAMP
RAMP
RAMP
RECEIVING
TRUCK DOCK
REC. OFFICE
UP
SCALE
OFFICE
OXYGEN STOR.
DN.
UP
ADMIT
ADMIT
WOMEN
ADMIT
TEL.
MEN
PHYSICIAN'S LOUNGE
LOCKER ROOM
TOILET
OFFICE
MECH. SHAFT
UP
FAN ROOM
MECH. SHAFT
INFO.
C O R R I D O R
RECEPTION
OFFICE
JAN. CLOSET
LOBBY
ENTRANCE
FOOD STOR.
SNACK BAR & GIFT SHOP
LOBBY
SECOND FLOOR
CONNECTING PASSAGE
ELEVATOR
STORAGE
ELEVATOR
SERVICE CORRIDOR
ELEVATOR
PUBLIC CORRIDOR
FLUOROSCOPY
FLUOROSCOPY
TECHNICIANS LOUNGE
RADIOGRAPHY
DARK ROOM
RADIOGRAPHY
WOMEN'S DRESSING ROOMS
HOSPITAL WAITING
CORRIDOR
WET FILM VIEWING AND SORTING
DRYING ROOM
RADIOGRAPHY
MECH. SHAFT
CORRIDOR
CORRIDOR
CORRIDOR
ASST. RADIOLOGIST
RESIDENTS
ANGIOGRAPHIC ROOM
HEAD ROOM
PUBLIC WAITING
OFFICE
FILM FILING
GENERAL VIEWING AND CONFERENCE
DICTATING
SECRETARY
RADIOLOGIST OFFICE
THIRD FLOOR
CONNECTING PASSAGE
LAUNDRY CHUTE
ELEVATOR
ELEVATOR
SERVICE CORRIDOR
ELEVATOR
PUBLIC CORRIDOR
PHOTO LAB
PHOTO UNIT
URINE LAB
CLINICAL CHEMISTRY
TISSUE LAB
SURGICAL PATHOLOGY
OFFICE & SECRETARY
TECHNICIANS LOUNGE
REST ROOM
OFFICIAL LAB
FLAME PHOTO
VESTIBULE
OFFICE
WAITING
BLOOD TYPING
CORRIDOR
CORRIDOR
MECH. SHAFT
SPECIMEN TAKING
SPECIMEN TAKING
GLASS STOR.
GLASS WASHING
MECH. SHAFT
CYTOLOGY
CORRIDOR
CORRIDOR
TRANSFUSION
BLOOD LETTING
PATHOLOGY
HEMATOLOGY
SEROLOGY
FILES
SECRETARY
DIRECTOR
LIBRARY & CONFERENCE
BACTERIOLOGY
OFFICE



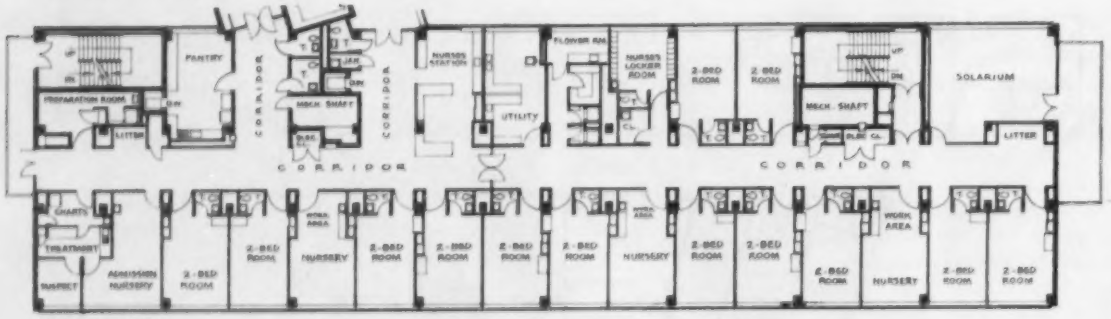
FIFTH FLOOR



SIXTH FLOOR



TYPICAL BED FLOOR



TENTH FLOOR

CONSTRUCTION DETAILS

Bed capacity: 226
Bassinets: 16
Planned for no additional beds.
Gross floor area 233,240 square feet.
Volume of building 3,146,934 cubic feet.
Total project cost (with equipment)..... $6,235,513.75
Cost per square foot..... $26.73
Cost per cubic foot..... $1.98

Cost data has been confined to the new building but a breakdown to cost per bed, as generally accepted, will not apply here because the first six floors of the new pavilion are entirely air conditioned and are devoted to ancillary facilities for a 1100 bed hospital. The laundry also is geared to take care of 1100 patients, plus personnel needs of the teaching institution.

An entirely new kitchen capable of serving up to 9000 meals per day was installed in the adjoining building at an additional cost of $600,000. Masonry walls of existing building were cut through on 11 floors to make bridge connections with the new pavilion and affected areas were remodeled to accommodate connections.

(*Continued From Page 56*)

system with standpipes and alarms is fed from standby water systems.

The most advanced air conditioning system has been designed for safety in preventing explosions in operating rooms. All of the air which is delivered to the operating and delivery suites is brought in from the out of doors, washed with air sprays, passed through filters and cleaned with electrostatic precipitators before it is introduced into the operating and delivery rooms. Entering these rooms through special grilles in the ceiling, it is discharged to form a blanket of fresh, treated, humidified air which is then exhausted from these areas through grilles located low in the operating rooms, from which it is carried directly to the out of doors and in no case is recirculated. Any explosive mixtures are carried out of the building at the rate of as much as 20 air changes in each room each hour.

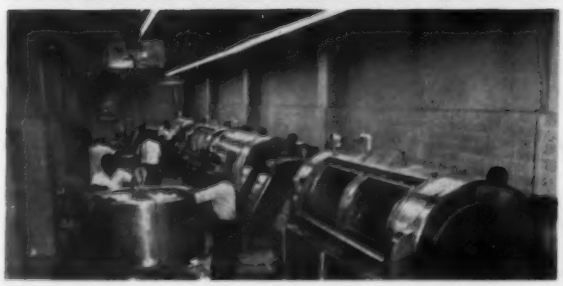
All areas in which ether or other explosive anesthetics are administered have static arresting floors in order to control the discharge of the static electricity from personnel without causing electric sparks. These floors are grounded to the steel frame of the building and these areas have meters for measuring the resistance of the bodies of personnel working in the areas. The entire electrical system which serves these so-called hazardous areas has been fed through special isolating transformers and equipped with explosionproof electric receptacles.

Outdoor stairways, which are hazards in the winter, have been eliminated.

A special off-street loading dock has been planned for handling delivery of supplies to the buildings.

Clinical chemistry laboratory occupies one section of the pathological laboratory suite housed on the third floor.

High-speed mangles in the laundry help employes to turn out 25,000 pounds of linen in eight-hour day.



Another view of the new laundry, showing the monorail system which speeds linen on its way from one process to the next.

8. The new structure has been equipped with all of the known labor saving devices for patient comfort and staff efficiency in rendering their services to the patient.

Each bedroom has private toilet facilities and many have private bathrooms.

An electronic message sending system has been installed which permits any one of 16 stations to communicate with another station by an electronically transmitted written message taking 1/60th of a second for transmission.

The operating rooms have been equipped with television conduit for televising operating procedures to viewing points for educational purposes.

Every patient's bedside is equipped with a voice receiver and transmitter for the purpose of contacting the nurse at the nurses' station. The nurse and patient can carry on a conversation without disturbing other patients. This saves many trips from nurses' station to bedside.

Every bedside has a telephone which feeds through an intramural dial system.

A remote voice dictating system has been installed for the convenience of doctors in dictating their records from various points in the hospital directly to the record room.

A high-speed dumb-waiter system has been installed for dispatching vital sterile materials from the sterile supply center to operating rooms and to patient areas.

9. The first six floors of the hospital are completely air conditioned and the upper eight floors are power ventilated and heated with forced hot water to respond to sudden temperature changes.

10. Every patient's room has flush in-built storage units to conserve space and present an orderly room.

11. A new kitchen has been installed in the existing hospital with a capacity of serving 9000 meals per day.

12. Every patient's room has its own piped oxygen system, nurses' call system, heating control system, and special patient controlled reading and general room lighting.

13. A laundry in the basement of the building receives all soiled linen from the floors by means of laundry chutes and is the most modern, fully mechanized, institutional laundry in Philadelphia, with a capacity of 25,000 pounds per eight-hour work day.

The proctor system of personnel training has many advantages, the chief one being that

Employes Learn to Teach One Another

W. B. FORSTER
Assistant Director, City Hospital, Akron, Ohio

BORROWING a system or a procedure from industry, commerce or another hospital seems to be an accepted practice in solving administrative problems. A borrowed system, however, like borrowed clothing, is not entirely satisfactory unless it fits.

A system of personnel training which was observed in one of the nation's leading department stores seems to merit consideration because it apparently fits the hospital situation better than some of the more commonly used methods. This store called its program a "proctor training system." The word *proctor* is defined by Webster's New International Dictionary as, "One who supports or protects; a patron, an advocate." One nonsupervisory employe from each of the various departments of the store is sent to the personnel department to learn how to teach his job to new workers. This person is then made responsible for the new worker until he is able to perform his duties without assistance.

ORGANIZE JOB CONTENT

To borrow this system for the hospital, one has only to organize the content of any job into its most teachable form, and then teach an experienced, capable worker the simple technics of teaching this material to the new employe. The job trainer, or proctor, thus prepared may then "adopt" a new employe, train him, and look after him until he is able to accept his new responsibilities.

There are several factors which would lead one to the conclusion that the proctor system fits hospital training needs. The first of these is brought about by the technical nature of our work and the necessity for high standards which requires a department head to exercise relatively close control over his department and thus he must maintain the responsibility for the training of his workers. But these very factors also make the department head a very busy person. Thus a program in which the department head can exercise complete control over the content of the training material, but the actual work of training can be delegated to one of his own employes, would seem to meet a real need.

A second factor which would point toward the proctor system for hospitals is that, to many lay people, the hospital presents a strange and awe-filled life which is completely foreign to them. A worker's adjustment to a new job is always a disturbing experience, but the adjustment to hospital employment to many new workers is almost forbidding, and about the second or third time someone speaks harshly to them because they do not know what is expected of them, many of them think that it isn't worth the effort and proceed to turn in their locker keys and uniforms. This situation is evidenced by the fact that much of the hospital's turnover occurs within the first few weeks of employment. Much of the proctor's value lies in the fact that he is by the new worker's side during that adjustment period.

In classroom training the new worker finds it necessary to adjust to the classroom situation, and then, when he receives his assignment, he must readjust to the work situation. In the proctor system there is but one such adjustment because the employe is trained under actual working conditions.

Still another characteristic of hospitals which would point to the proctor system is the comparatively large number of job titles. This situation means that even in the large hospitals there are relatively few times when more than one new employe of any particular job classification is hired at any one time. In discussing methods of personnel training, Tead and Metcalf's text "Personnel Administration" says, "The centralization of job training has proved feasible where there are many workers to be simultaneously trained at the same job; the local or departmental method, where a few workers are being qualified for a wider variety of operation."

LOCALIZED TRAINING ADVANTAGEOUS

This localized type of training is of advantage even on the few hospital jobs in which there are a larger number of employes under the same job classification. To illustrate, a nurse's aide on a medical unit may perform the same tasks as the aide on a surgical or obstetrical unit, but because of the difference in the nature of the patient, her attitude, her conversation, or even the tempo of her work may differ. Thus an aide who is to work on a medical nursing unit may do a better job if she is trained on a medical unit than if she is trained in a group with surgical and obstetrical aides.

The City Hospital of Akron replaced its classroom training with the proctor system early in 1953 with gratifying results. The nurse's aide group was the

first to try the program. Turnover in that group had been the highest in the hospital, with a rate of 9 to 10 per cent per month. At the end of two months under the new training program that rate had dropped to 4½ per cent and, from the sixth month on, has varied from 1 to 3 per cent. In addition, the quality of the work done by the aides has improved noticeably.

The starting point in the proctor system, as with any training system, is the preparation of material to be taught. This should be a cooperative project with the entire supervisory staff of the department contributing ideas. The collecting of this information, the writing and the coordination of the program may be done by a member of the personnel department. In a hospital large enough to warrant a full-time person to do this work, the title "Training Coordinator" fits well.

The body of this training material consists of a job breakdown. In this process each job is divided into tasks and each task into steps. Most tasks consist of three subdivisions: make-ready, do and clean-up, and the steps should be so divided. It is important that all supervisors, proctors and employes understand that no task is complete until the clean-up is finished.

An example of such a breakdown from an aide's manual is shown in the accompanying chart.

This breakdown process does far more than provide training material, although that is the purpose of the effort. As side benefits it causes the department to reconsider its processes, institute improvements in its methods, and to standardize the results.

After a particular job has a complete set of tasks in breakdown form, the supervisory staff has agreed on them, and the department head has approved the results, the training coordinator may then compile them into a training manual for the use of the proctors in training new employes.

The selection of proctors is an easy task. They should be close enough to the work that they know the details intimately, but they need not be the same job title. For example, a senior nurse's aide makes an ideal proctor for the new aide. The head tray girl on a nursing unit does a better job in training than the tray girl does. The important factor to consider is that there should be enough proctors in the classification chosen so that each new worker can get an adequate amount of attention while he is being trained. If a proctor must handle two trainees at the same time, the effectiveness of the program is reduced. In all instances, the proctors are chosen from a group no higher in the organization than line level supervisors, and usually they are from the worker level.

Of course, it is obvious that, although the proctor may be the very best worker, he may do a poor job of personnel training if he doesn't know *what* to teach or *how* to teach. Thus, after the proctor is selected, a workshop course is held in which he is given the training manual which tells him what to teach presented in the most teachable form, and is given instruction and practice on the best teaching method.

Many personnel training executives agree that the best training method is, "Tell 'em, show 'em, let 'em try, crit-

CHANGE LINEN WITH PATIENT IN BED

MAKE-READY

1. Obtain 1 sheet and 1 pillow case.
2. Place chair near bed and arrange the linen on it.

PROCEDURE

1. Remove the pillow and place on the chair.
2. Loosen the bedding on all sides; lift mattress to avoid tearing the sheet.
3. Place spread folded in fourths on chair back and see that the mattress is to head of the bed.
4. Place bath blanket over patient.
5. Place folded top sheet on chair.
6. Ask patient to turn to opposite side of the bed; assist patient if necessary.
7. Roll soiled draw sheet toward the patient. Tighten foundation sheet and rubber draw sheet.
8. Use sheet removed in step 5 as new draw sheet, place over bed and tuck in.
9. Assist the patient to roll toward you (be gentle).
10. Go to opposite side of the bed and pull soiled sheet off (do not throw soiled linen on the floor).
11. Bring the clean draw sheet through, and tuck securely.
12. Place clean sheet over the patient wrong side up, center it, and form 8 inch cuff at the top by folding top of sheet back.
13. Reach under the sheet and remove the bath blanket; fold the blanket and store in the dresser.
14. Make 2 inch toe pleat at foot of the sheet.
15. Place spread on sheet, tuck in at foot, and miter the corners.
16. Pull cuff over spread and straighten the spread and sheet.
17. Change the pillow case and place pillow under the patient's head.
18. Pin paper bag and signal cord within reach and see that signal cord works properly.

CLEAN-UP

1. Straighten the unit.
2. Remove the soiled linen.
3. Discard in the proper hamper.

Here, a senior nurse's aide proctor employs the "tell 'em, show 'em, let 'em try" method of instructing a new employe in the proper way to make a bed.

icize and repeat until the teacher is sure the learner has learned." To illustrate how this method operates, it might be helpful to follow a proctor through the bedmaking process.

After the proctor has received her work assignment from the head nurse, she would take her learner aside and go over the job breakdown with her step by step. That is the telling portion of the process. Then the two of them would go get the linen and the learner would watch while the proctor made a bed. That would be the "show 'em" step. Then as they go on to the next patient, the proctor would stand back and let the learner make the bed with the proctor correcting those steps which the learner performs incorrectly. If the learner doesn't seem to have grasped the idea at all, the proctor may think it advisable to go back over the telling and showing process again. If, on the other hand, the new aide has done pretty well but has erred on just a few points, the proctor may have her make several beds until the proctor knows that this task has been mastered. Then the two can go on to the next task. They practice this teaching method on each other until they know how to teach.

A training manual may have from 20 to 40 different tasks broken down for the various hospital jobs. It would be rather difficult for the proctor to remember whether she had covered the entire job with any one new worker unless there were a check list on which the various tasks could be checked off as the learner progressed. The bottom of the check list may contain a statement something like this: "I certify that ..... (employe's name) has completed his training and is ready for assignment. Signed ..... (proctor)."

As a complement to proctor training, there may well be an orientation program for communicating that information which all hospital workers should know, regardless of their position in the organization. It could contain such subjects as a brief history of the hospital, the board of trustees and how it functions, the organization with the names of the department heads, facts about the hospital with some things to be proud of, safety and fire prevention, how to behave in a hospital, and human relations pointers. All sorts of visual aids may be used.

The frequency of the orientation classes is a much discussed subject. It would seem that the number of new employes hired would control the number of times per week the class is held. A class with fewer than three or four trainees would probably be a waste of time. On the other hand, one person cannot conduct a good tour for more than six or seven people. Thus a hospital which hires more than 20 employes per week would probably want daily classes Monday through Friday. Twice a week would probably be adequate for from six to 15 new employes. No employe should have to wait more than a week for his introduction to the hospital.

The proctor system of personnel training, coupled with a good orientation program, has much to recommend it to the hospital administrator. It provides adequate training for employes under the control of the department head without burdening that department head to the point that the work of the department is sacrificed. Morale is improved because the workers themselves have a hand in training each other and because well trained employes have more pride in their jobs —they have a yardstick by which they can measure their effectiveness. Turnover in the early weeks of employment is all but eliminated because the adjustment to the new job is made while the proctor is at the worker's side to help dispel frustration and the feeling of uselessness which causes new employes to quit.

What is perhaps most important of all, the supervisor is able to do a more effective job because many of the supervisory duties become a matter of routine and the time thus saved can be used in thinking of ways to improve the department.

Michigan Doctor Sues Nonprofit Hospital, Demanding Staff Privileges Under State Law

LANSING, MICH. — The Michigan Supreme Court decision in the case of Albert *vs.* Grandview Hospital (Ironwood) has resulted in another suit in which a doctor claims the hospital has no right to exclude him from full use of hospital facilities, it was reported here last month.

In the Ironwood case, the supreme court ruled the hospital had violated state law when it denied staff privileges to Dr. Samuel Albert (The MODERN HOSPITAL, December 1954, p. 82).

Defendants in the new lawsuit are the Allegan Health Center at Allegan, Mich., its medical staff, the Allegan County Medical Society, Michigan State Medical Society, and Michigan Hospital Association. The plaintiff, Dr. William A. Kopprasch, contends every patient at the hospital has the absolute right to employ his own physician, and the physician is entitled to have exclusive charge of the care and treatment of the patient.

Plaintiff Kopprasch has asked the court to rule that hospital regulations preventing a duly licensed physician from using hospital facilities in the practice of his profession should be voided. The suit also asks for reimbursement of income lost because plaintiff has been denied use of hospital facilities since 1943.

"This suit clearly demonstrates that the supreme court's decision regarding Grandview Hospital will be used to attack the rule-making power of other hospital governing boards, despite the fact that other governing boards may be created under different legislative acts," the Michigan Hospital Association stated. An association bulletin pointed out that the Allegan Health Center is a nonprofit hospital. However, the Kopprasch suit alleges the health center is a public hospital because the building and land upon which it rests are owned by the city of Allegan.

Dr. Kopprasch first lost his hospital privileges in 1943, when his medical license was revoked. His license to practice was restored in 1948, but he had not been readmitted to use of the hospital.

At a meeting of a joint liaison committee of the state hospital association and the Michigan State Medical Society, the Allegan lawsuit and its meaning in terms of hospital-medical relations were discussed at length, the hospital association bulletin reported. "The committee took a long look at the forces leading to present legal decisions and lawsuits aimed at isolating hospitals as to quality of medical care," the bulletin said. "It was suggested that both parent bodies unite in countering this attempt to relax control. Those present at the meeting were of the opinion that doctors and hospitals can solve their own problems, without the use of courtrooms."

New Law Takes Fraud Out of Fund Raising

How New York State safeguards contributions

CORNELIUS M. SMITH
New York City

A FAR-REACHING, history making step was taken toward prevention of fraudulent and unethical practices in the raising of money by hospitals and other health, religious, educational, welfare and cultural agencies when New York State placed on its statute books last year additions to the Social Welfare Law dealing with the solicitation and collection of contributions for charitable purposes.

The new legislation followed an extensive investigation by the Joint Legislative Committee on Charitable and Philanthropic Agencies and Organizations, of which the then State Senator Bernard Tompkins was chairman. The inquiry lasted nearly a year and was aided by the testimony and cooperation of such organizations as the American Association of Fund-Raising Counsel, the Catholic Charities of the Archdiocese of New York, the Federation of Jewish Philanthropies, the Federation of Protestant Welfare Agencies, the Greater New York Fund, the New York State Association of Councils and Chests, the United Hospital Fund, and the major veterans' organizations in the state.

$4,500,000,000 GIVEN YEARLY

Each year an estimated $4,500,000,000 is contributed to charitable and philanthropic causes by American citizens and, of that sum, more than $720,000,000 comes from the pockets of the people of New York State. During the investigation the public was shocked at "the sordid operations of certain fake charities and loosely or improperly run fund raising appeals"—in the words of Senator Tompkins.

The senator was quick to add, however, that the number of such "fake organizations and unprincipled individuals is relatively small," and that there is a "vast array of noble and useful philanthropic services and organizations" which are "among the finest manifestations of American freedom and brotherhood." Referring to professional fund raising counsel, Senator Tompkins said: "These ethical firms render most valuable aid to the legitimate philanthropic organizations of our state in their fund raising efforts."

An encouraging aftermath of the New York State law is that many other states are considering the enactment of similar safeguards for the American philanthropic movements in their areas. Moreover, a subcommittee of the committee on the judiciary of the United States Senate, taking its cue from New York, has held hearings on the possibility of national legislation along similar lines.

The realistic approach to the problem of regulating fund raising activities is apparent from remarks made by the Hon. Raymond W. Houston, state commissioner of social welfare, at a meeting in Albany shortly after Governor Dewey signed the bill. Commissioner Houston emphasized the following four points relative to the operation of the provisions of the law and their purposes:

Their operation must proceed in a somewhat experimental manner while their interpretation is clarified by practice, by opinions of the attorney general, or even court decisions.

The department of welfare does not intend to create any list of approved charities.

It is not the purpose of the department to be unduly rigid in enforcing the laws and that the basis of action might often be the intent rather than the deed.

There will be no effort to fix a standard of "fair expenses" in raising money.

At the same meeting, Senator Tompkins and Assemblyman Samuel Rabin, members of the committee which drafted the law, emphasized that the new legislation was not intended to hamper or hinder any legitimate charitable effort, but rather the intent was to be constructive.

It is obvious from these statements that it is not the new law's prime purpose to regulate charitable organizations and professional fund raisers but rather to gather and make available full information regarding charitable enterprises and fund raising activities in order to help reputable charitable organizations and the contributing public to protect themselves.

USE VOLUNTEER FUND RAISERS

Because the law applies to the varied methods used by charitable organizations and persons or firms in financing philanthropy, such inclusive terms as "professional fund raiser" and "professional solicitor" are used. Applied to the hospital field the term "professional fund raiser" is an individual or firm of fund raising counsel. Seldom, if ever, do fund raising counsel in this field employ paid solicitors. Subscriptions are sought only by volunteers. Therefore, in discussing the new law the term "fund raising counsel" will be employed.

The main provisions of the new law, as applied to hospitals in New York State, work out as follows:

1. A hospital intending to seek

contributions within the state of New York must register by filing with the department of social welfare, before beginning solicitation, the name and the names of its officers, directors or trustees and executives and any fund raising counsel or "professional solicitors" if any, who will act on behalf of the hospital. Moreover, the salaries, bonuses, commissions or other remuneration to be paid to such counsel or solicitor must be included.

2. In this registration, the hospital must state the purposes for which the money is to be raised and the period of time during which the solicitation is to be carried out. A fee of $5 is required.

3. A written report also must be filed by the hospital in the year after a fund raising campaign has been conducted, containing a financial statement covering the preceding year and giving the gross income, expenses and net funds obtained by the hospital. The report also must contain the names of the hospital's fund raising counsel or "professional solicitors" if any, and compensation received by them. The law does not regard a bona fide employe or officer of a hospital as a "professional fund raiser," or as a "professional solicitor."

4. Fund raising counsel may not serve a hospital in New York State until it has registered under oath with the department, has paid a fee of $50 and has put up a $5000 bond. All contracts between a hospital and fund raising counsel must be available for inspection by the state commissioner of social welfare.

5. Should anyone be employed to solicit contributions for a hospital he is considered, under the law, a "professional solicitor," and must register with the department and pay a fee of $10.

6. Enforcement of the law is placed in the hands of the attorney general of New York, or his deputy, who is given all the powers which otherwise would be used by a district attorney.

The statute does not set up an inquisitorial body, and, except for violations of the requirements of the new act itself and the unauthorized use of persons' names, it does not define any specific illegal acts or establish any penalties not already authorized by law.

For instance, the attorney general may prosecute for the use of any "device, scheme or artifice to defraud," or for obtaining money under false pretenses.

Of course, in addition to the usual penalties for such acts, a hospital, its fund raising counsel or solicitor may be enjoined from continuing such illicit fund raising and their registrations may be canceled.

In order to prevent one of the most flagrant violations of fund raising ethics, the new law prohibits the use of the names of persons without their written consent. This includes "listing them on stationery, advertisements, brochures or correspondence," or to refer to any such person as having "contributed to, sponsored or endorsed" the hospital or its activities. Violation of that section of the law "shall be a misdemeanor."

Certain organizations are exempted from the provisions of the law. The exemption clause as it would affect hospitals reads:

"This article shall not apply to corporations organized under the religious corporations law, and other religious agencies and organizations, and charities, agencies and organizations controlled by or in connection with a religious organization."

Admittedly it remains to be proved by actual experience during the first year of operation how effective and practical all of the new law's provisions will be. Certainly neither the framers of the statute nor the legislature in enacting it had any desire to set up unenforceable or unreasonable regulations that would injure the very persons and organizations whom the law aims to protect.

The new statute has been referred to as a long step in the right direction, which had been overdue for years. It places on record and brings out into the open all who are engaged in fund raising. No longer shall it be possible for unscrupulous persons or organizations to carry on fraudulent or unethical fund raising practices under cover—an objective which the American Association of Fund-Raising Counsel and all other ethical fund raising counsel and charitable institutions have long hoped to achieve.

Iowa Doctors Move to Establish Own Hospital to "Preserve Freedom of Selection of Physician"

DES MOINES, IOWA.—A move by one county medical society to by-pass existing facilities and investigate the possibility of establishing its own hospital was the only major development in the Iowa doctor-hospital controversy last month. State hospital and medical associations were awaiting a ruling by the district court here in connection with the hospital association's suit for declaratory judgment of hospital rights to charge for laboratory services.

Meanwhile, hospital and medical groups had compromised their differences on pending Hill-Burton enabling legislation. The compromise bill, according to Ray H. Johnson Jr., Iowa Hospital Association counsel, excludes a controversial provision in the original bill sponsored by the medical society which would have withheld Hill-Burton aid from hospitals denying staff privileges to any licensed physician.

Meeting in closed session at Council Bluffs, the Pottawattami County Medical Society authorized its executive council to investigate possible acquisition or construction of a new hospital, indicating this action emerged directly from the year-long controversy over "corporate practice of medicine" by hospitals employing radiologists and pathologists on a percentage basis.

Authorizing its executive council to retain architects and hire contractors if construction of a new hospital is deemed necessary, the Pottawattami society's resolution said that "after such hospital has been placed in operation, all members of this society shall encourage the use of the facilities of the hospital for patients, as such hospital shall, without limitation, preserve for the individual his freedom of selection of the physician or surgeon who shall treat and diagnose his illnesses and injuries."

Following this action by the county society, Mrs. Clara Strohbehn, president of the board of trustees of the Jennie Edmundson Hospital at Council Bluffs, said there was no need for a third hospital in that city. "The two we have can take care of Council Bluffs, and we are having trouble getting enough doctors and nurses now," Mrs. Strohbehn stated.

Donald Plunkett, business manager at Mercy Hospital, said if the medical society move meant better care of pa-

(*Continued on Page* 162)

Functional Color

IN THE MODERN HOSPITAL

Proper selection and coordination of colors will make patients happier and may actually speed recovery; in addition, colors in work areas should be chosen to improve work performance, reduce fatigue, and eliminate safety hazards

For a restful private room, the color consultant selected beige and soft blue-green to create an atmosphere of repose. There are no sharp contrasts here, but the warm tint of the furniture is picked up in the flowered pattern of the draperies; the dark covering of the armchair supplies needed accent.

WHAT IS COLOR?

AS THE accompanying diagram indicates, the electro-magnetic spectrum consists of wave lengths, only a very small part of which are visible to the human eye. The visible portion is neatly arranged in groups of wave lengths that science calls the visible spectrum. Each group produces an effect that we call a color.

At one end of the visible band is red; at the other end, violet. These wave lengths range from 16 millionths of one inch for the violet to twice as much, or 32 millionths of one inch, for the red. Beyond the red is the invisible infrared, and then a wide spread of radio waves within which is a small section constituting the broadcast band for radio and television.

At the other end of the visible spectrum, beyond the violet, are the ultraviolet, the x-rays overlapping the gamma rays (the atomic bomb gives off gamma rays), and—beyond them—the cosmic rays, all a part of the electro-magnetic spectrum.

A pure color or hue is produced by the central portion of each of those groupings in the visible spectrum. Hue is defined as the quality by which we are able to distinguish one color from another, such as red from a yellow, a green, a blue or a purple. Red, for example, starts mixing with yellow on one side of the band and merges into infrared on the other side. The pure red is called a *saturated* red.

Saturation, then, corresponds to the purity of a color. This is also known as *chroma.* But the way that color really appears to our eyes also is affected by *brightness.*

The *brightness* or *value* of a color is determined by the quantity of light energy reaching the reflecting surface, regardless of wave length. Value is the quality by which we distinguish a light color from a dark one. It is the function of value to tell us how light or how dark a given color may be. For example: A pink is a high value red, and a maroon is a low value red.

If an artificial source of light is noticeably lacking in one or more elements of the spectrum, it will correspondingly produce an inadequate or exaggerated color effect. For example, a source of light that is dominantly blue would have the effect of washing out or eliminating the blue in a surface and creating the appearance of a white surface.

Research also tells us that we never get back from any surface all of the light energy that strikes that surface. Even standard white will reflect only 92 per cent of daylight. What happens is that the light energy is absorbed by the density of the surface it strikes. And so, according to the scientist, decoration *modifies* light energy in a room.

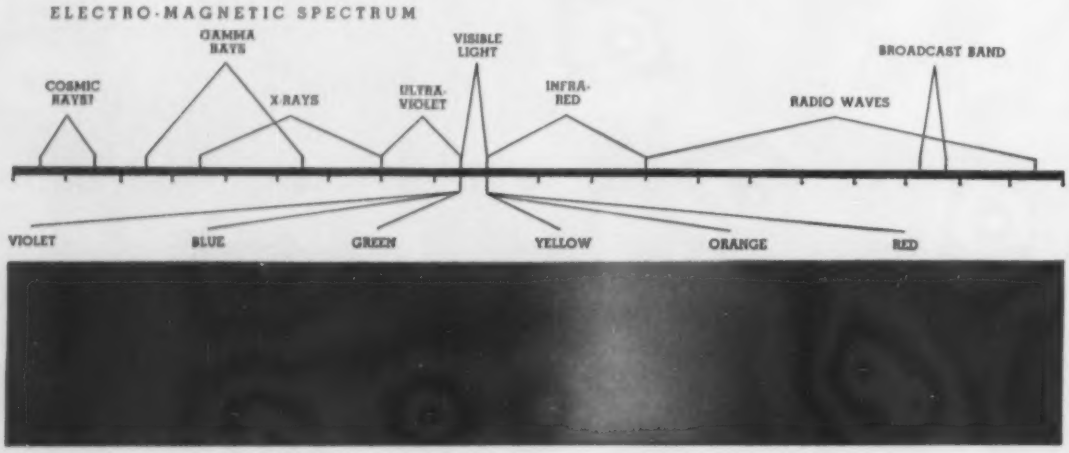
It's commonly supposed that each color has a tonal or emotional effect upon an individual, and research agrees it is so. But research does not agree as to *why* this is true.

The more commonly accepted explanation—that of the psychologist—is the *association of ideas.* Red suggests heat to us because of heat from a fire. Yellow suggests warmth from the sunlight. Blue connotes coolness because of blue waters.

Now, say physiologists, since the color red makes things appear closer to us, it causes us to be more alert and therefore we put out more heat energy. A dominance of red, then, in a room makes a person feel as if things were closing in on him. It gives him a warm feeling, and we call it a *warm* color.

At the other extreme, the color blue makes things appear to be farther away. Therefore it does not set up as quick a response in the human mechanism. So we consider blue as a *relaxing* color.

The *emotional* effect of light and of color is only one of several considerations when we plan the decoration of a room. We are concerned not only with how the person feels about the color but also—and perhaps even more important—with how well he can see and what kind of seeing is involved.



THE VISIBLE SPECTRUM

Functional Color in the Modern Hospital

HOWARD KETCHAM
New York City

IN THE San Francisco General Hospital an experiment was conducted to determine which colors would be preferred by incoming patients. At the time of admission, patients were permitted to select the color of the ward in which they would be placed. The color choices ranged through blue, ivory, apple green and pink. Since the vast majority of patients expressed a preference to be located in areas colored apple green, the hospital solved its problems by painting all ward areas in this shade.

Even though most hospitals would find it impossible to adopt this system in planning colors for rooms, waiting areas, and other interior surfaces, this experience proves a number of things for us today. It is just one more good example that color is important in hospitals—as vitally important as it is in every other phase of life. We have only to close our eyes or turn out the lights to sense the flatness of life without colors. Few things in nature give us more immediate or varied pleasure than the perception of color. Nothing speaks more directly to our senses.

In dealing with color, it is well to consider that color is a sensation conveyed to the mind by the intricate functioning of millions of tiny, cone-like structures located in the retina of the eye. Since we get no less than 87 per cent of our impressions through our eyes, it is vital that we remember how powerfully color contributes to what we see and how profoundly color influences our wants. Although color lacks size, shape and weight—and cannot be seen without light—it is one of the most potent therapeutic and psychological tools that the modern hospital can use.

Why is this true? Simply because color can make a patient feel that he is in friendly, homelike surroundings; because colors, properly chosen and coordinated, can make hospital wards and rooms more of a pleasure to be in; because people want and get color in all their other activities of life. Americans are no longer hesitant about using color in their homes. In fact, each home furnishings market shows a wider use of hues and tones that were once monopolized by the decorator.

Look around you. The traditions overcome by modern color styling are innumerable. Here are just a few:

1. Homes were once predominantly white; now they are multicolored.
2. Telephones, pens and automobiles, traditionally black, now come in every color you can think of.
3. White appliances and kitchens are now seen in endless colors.
4. Color is here to stay in men's attire.
5. Desk tops are no longer black or brown, nor are typewriters always black.
6. Paints, plastics, papers, inks, fibers, metals—they are all brighter than ever.
7. Factory interiors have changed. Color in work environments is used for safety and improved morale.
8. The boom years in color television are just ahead.
9. Ships of the fleet are now colorful.
10. The transportation field is in the midst of a color revolution.
11. School classrooms, walls and furniture are bright and cheerful. Even "blackboards" are green or yellow today!

People do not want to be so many peas in a pod. This attitude is reflected in the way they are buying and decorating homes. They are buying color-styled homes and using color at an ever growing rate, as my work as color-planner for prefabricated homes has shown me. There is every good reason in the world why the hospital planner should follow this vitally important trend.

The attractiveness of most present-day living rooms has already had a direct repercussion on many industries. For example, auto interiors, transport airliner interiors, and railroad cars have been affected.

Within practical limits, the same type of color-styling seen in residences and elsewhere should be applied to hospitals.

How does the hospital planner go about giving his building proper color-coordination? Do you copy the color plans of older hospitals and retain ineffectual white? (White, of course, is being seen less and less in today's kitchens, today's appliances, today's interior decoration schemes. The trend now is definitely to related colors in the home. This is one of the most important things for the hospital field to remember. For if people want color in their homes, it is more than likely they will feel at home in colorfully styled hospitals.) Or do you simply go along hit-or-miss, using colors such as burnt-plum, gray and similar nondescript shades, without guidance?

Actually, you don't have to do any of these things. The key to success in the over-all appearance of your hospital lies in the proper use of one or more of the six basic color families —red, orange, yellow, green, blue, violet. With them there is absolutely no limit to the variety of good color schemes the imagination can create. And attractive color individuality can give your hospital the greatest opportunity of attaining a distinctive, homelike atmosphere and thus contribute materially to the comfort and well-being of hospital patients.

Of course, distinction and beauty in color choice are not enough to give the full value of color's vast potential worth to your hospital. Color utilization depends on different factors, such as psychology, or the association of color and ideas. For example, color has a somewhat uniform influence on the psychological reactions of most people. In selecting a color theme

Color plate on page 66, courtesy, Pittsburgh Plate Glass, Inc., Pittsburgh; color plates on pages 65, 68, 69, 71, courtesy, Hill-Rom Company, Inc., Batesville, Ind.

for any purpose or use, it is therefore desirable to first determine the mood you wish to create on the beholder, and then select the colors that will tend best to produce the effect desired.

Some of the effects of color may be listed as:

Red is exciting.
Orange is activating.
Yellow is cheering.
Green is refreshing.
Blue is cooling and subduing.
Purple is depressing.
Magenta is stimulating.

These effects should be remembered when hospital rooms are being planned. The therapeutic aspects of color styling and lighting coordination should be guides in developing the plans.

In successful advertising and display art, the psychological aspects of color are today capably and constantly brought into play. The implication of heat is delineated by the use of red, a warm color; and freshness with green, which from time immemorial has been associated with vegetation. Cold can best be featured in blue, since blue is traditionally considered a "cold" color. Thus you should consider the individual aspects of each of these color attributes as it concerns the hospital.

Colors cannot be readily distinguished, one from the other, without proper contrast. Color contrast can be attained in only four ways:

1. Use a light value of a color against a dark value of the same color or vice versa (pink on maroon).

2. Use a weak saturation as chroma of a color against a strong chroma of the same color, or vice versa (emerald green against pale green).

3. Use a warm color against a cold color or vice versa (orange on blue).

4. Use a color against its comple-

Color plan for a private room. A cheerful creamy pink is the dominant color. No sharply contrasting colors are used so that the over-all effect is restful and soothing. There is no monotony because the dark and light surfaces of the furniture are picked up in both the color and the design in the draperies.

For a modern looking semiprivate room, the consultant selected contrasting shades of cool green-blue and warm rose-red. The effect is homelike and makes the room a pleasant one in which to convalesce. The light pink tint of the furniture strikes a new note that is as modern as it is practical.

ment (red on green, yellow on purple-blue).

In my opinion, too little has been presented on the effect of paint and paint colors in increasing hospital lighting and efficiency. Yet this is of great importance. The problems of hospital lighting are different from those of residential and commercial lighting, first because of the technical demands encountered in hospital rooms and second because of the different angle of view. For example, to a supine patient the headwall becomes his ceiling, the opposite wall his floor, and the ceiling his facing wall. The large amount of hospital construction now in the planning stage justifies more attention to the lighting of patients' rooms and also to working, surgical and other areas.

The dull or gray walls and ceilings of many hospitals, dark bands around working areas, unfinished or gray floors, and dull colors on most equipment contribute little to proper light distribution. In some cases these colors may decrease the effectiveness of modern lighting by as much as 50 per cent. In every case they cause a decrease in personnel efficiency.

The proportion of light reflected by wall covering of various colors has an important bearing on both natural and artificial lighting. The proportion of light reflected depends somewhat upon the color of the light source. The list of colors in the order of their light reflecting efficiency (see page 70) is essential in evaluating functional color for hospital use.

To ensure evenly lit, glareless areas for a certain interior, I recently designed a new lighting fixture which brings out true colors in the most undistorted way. The lamp housings in these fixtures are equipped with a perforated aluminum baffle which

permits some of the light to come through, but directs most of it down. To offset the fact that the four cool white lamps in each fixture cast a light that is a trifle blue, I enameled the lamp deflector base with a certain shade of ivory. The light reflected from this ivory surface picks up a warm tinge, and the resultant total light cast is white instead of bluish, as it would have been had not color-correction been provided. This color-corrected lighting does its job to perfection, without distortion.

Good color selection in painting can bring about clear, three dimensional vision instead of the dull, flat effect produced on the eyes by drab or dark painting of equipment, ceilings, walls and floors. When we paint to provide all surfaces with proper reflection value we bring out a marked increase in light utilization. Such painting provides positive visibility with finishes having high reflection factors by means of adequate contrast in hue, an over-all contrast which is not too harsh to prevent continuous and comfortable seeing, and a color sensation which is psychologically pleasant and easy to work with.

Eye fatigue, it has been demonstrated, is caused by unnecessary travel of the eye over ill defined areas, tension in holding the eye on work where the surrounding areas are of about the same color, and constant adjusting when changing from light surfaces to dark surfaces. Proper colors center the worker's attention on working points. Receding colors on surrounding equipment or parts of the same unit cause these to drop back and relax the eye.

Any attention to equipment painting should thus be accompanied by a corresponding care regarding walls, columns, partitions, doors and other objects or areas within the workers' field of vision. Walls and columns should have approximately the same general tone of color (not necessarily the same color) as work units and areas. For example, a certain type of light green is excellent for walls within the workers' vision as they glance up from their work, and a brighter color, such as yellow, is good for other walls to gain the benefit of simulated sunlight. If the ceiling has little reflection value, a lighter color can be used to produce this blending effect.

For indirect lighting, of course, colors with a high reflecting value are necessary. In the hospital, proper fluorescent lighting and fixture design and/or selection will provide higher intensity, more even distribution of light, and less heat radiation. Proper design will also improve the natural appearance and value of colors, increase efficiency (more footcandles per watt input), and improve downlighting. Properly developed lighting plans, engineered individually for the specific conditions peculiar to each hospital, will do much to provide warm, homelike surroundings, improve visibility, act as a therapeutic agent, and reduce unnecessarily high maintenance costs.

One interesting and economical lighting-and-color plan for a private or semiprivate room and ward areas might involve the use of only a single color in the room: white! This white could then be altered by means of lights equipped with color filters adjusted to any color the patient prefers —or one that will help in his recovery. With a single color, and multiple filters for the light source, a hospital can thus achieve almost unlimited variety in color styling.

Different colored filters can, of course, change white light to any color, but they have a decidedly dif-

LIGHT CORRELATION CHART

Color of Light	Color of Pigment	Resultant Hue	Value*	Chroma**
RED	Red	Unchanged	Raised	Unchanged
	Yellow	Yellow-Red	Raised	Unchanged
	Green	Brownish Gray	Raised	Unchanged
	Blue	Reddish Gray	Lowered	Unchanged
	Purple	Imparts Yellow-Red	Raised	Strengthened
YELLOW	Red	Yellow-Red	Raised	Unchanged
	Yellow	Yellow	Unchanged	Unchanged
	Green	Yellow-Green-Yellow	Raised	Weakened
	Blue	Grayed Yellow	Lowered	Strengthened
	Purple	Brownish	Lowered	Weakened
	Purple-Red	Burnt Orange	Raised	Weakened
GREEN	Red	Brownish Gray	Lowered	Weakened
	Yellow	Lemonish Yellow	Raised	Weakened
	Green	Neutral Green	Unchanged	Unchanged
	Blue	Bluish Green	Unchanged	Weakened
	Purple	Grayish Brown	Unchanged	Weakened
BLUE	Red	Reddish Purple	Unchanged	Weakened
	Yellow	Neutralized	Unchanged	Weakened
	Green	Blue-Green	Unchanged	Weakened
	Blue	Unchanged	Unchanged	Strengthened
	Purple	Grayed	Lowered	Weakened
VIOLET	Red	Bluish	Lowered	Unchanged
	Yellow	Neutralized	Lowered	Unchanged
	Green	Violet-Gray	Lowered	Weakened
	Blue	Slate Blue	Lowered	Weakened
	Purple	Purple	Raised	Strengthened
PURPLE	Red	Bluish	Unchanged	Unchanged
	Yellow	Grayed	Lowered	Weakened
	Green	Grayed	Lowered	Weakened
	Blue	Blue-Gray	Unchanged	Unchanged
	Purple	Unchanged	Lowered	Unchanged

*Value—the brightness of a color.
**Chroma—purity or saturation of a color, e.g. an olive green is a chromatic green whereas an emerald green is a strong chromatic green.

Light Reflectance Values of Various Colors

Color	Reflectance
White	80 per cent
Light Ivory	77 per cent
Medium Ivory	73 per cent
Butter Yellow	70 per cent
Pale Green	63 per cent
Buff	60 per cent
Pale Blue	50 per cent
Pink	50 per cent
French Gray	39 per cent
Medium Blue	39 per cent
Medium Green	39 per cent
Gray	20 per cent
Red	16 per cent

ferent effect on colored pigments. The "light correlation" chart on page 70 shows what can be done with colored lights on various interior colors.

The selection of floor color in hospitals is particularly important today. Unfortunately, too many hospitals consider flooring merely as a utilitarian adjunct without adequate regard for the significances proper color in floor surfaces can contribute. A floor can reflect or absorb light. It can complement the décor of the room or inflict a hideous discord, or merely be innocuous.

Floors in patients' rooms should be in light colors with good reflectivity. Even where it is not necessary to have light floors it is best to keep the aisles light and to band them along each side with a distinctive and bright color to form traffic lanes. This effect can be achieved with contrasting tiles or colored terrazzo or composition flooring.

Moving equipment is always an accident hazard, but this factor can be reduced by proper and distinctive painting. Trucks should be painted yellow all around, including any side projection, because this color has high visibility. If the insides of moving receptacles are painted in light colors it is easier to see the contents.

It should be remembered in such color planning, however, that painting does not take the place of guards and safety devices on equipment. Nor does it remove the need for the use of red to indicate fire exits, fire fighting equipment, switch boxes, emergency stops on machines, and other safety installations or danger points.

The standard identification colors used on equipment and accessories in the hospital should not be changed unless they are of a nature to hide rather than set off such units. Workers have learned, through years of experience, to associate these given colors

This is a quiet room, carried out predominantly in a soft and unusual shade of blue. The color is used throughout to make the room appear larger. The reddish brown of the furniture imparts the needed warmth, while drapery and slipcover materials combine both colors in a satisfying and unobtrusive design.

with specific things and responses are automatic more by the sight of the color than the unit involved. Such acquired habits may take a considerable length of time to change.

Progressive hospital planners today are getting away from conventional seat covering materials for both private and public rooms. The current trend is to seat coverings in serviceable, cheerful colors. New materials are relatively inexpensive and can easily be wiped clean to keep color effects fresh and long-lasting.

Window curtains are following the same trend. In fact, in many progressive hospitals they are being eliminated entirely in favor of colorfully painted frames and mullions. Such functional window colors can complement interior décor and present a cheerful aspect to the exterior of the building as well.

Where window curtains are being used, it would be wise to consider reversible shades that have a light color on one side and the other dark to harmonize with both interior and exterior décor. Of course, it is essential to select an opaque shade that does not show through, so a room can be darkened in daylight hours. If venetian blinds are preferred, the reversible scheme can also be adopted and cheerful color accents can be produced by using colored tapes and pull cords.

Here is a bright, new idea for hospitals: polka-dot paint, a new specialty lacquer in which fine droplets of different colored lacquers are suspended in an aqueous medium. The color used in the largest quantity appears as the background when the lacquer is sprayed, while the other colors appear as dots in relief on the surface. The product finds its most important outlet in furniture finishes. Another potential use in hospitals is to provide an unusual decorative effect for interior walls.

Probably the most important single aspect of color coordination for any hospital room is the blending of all furniture, bedspreads and draperies with the general décor of the room. Qualified professional services are available today to help hospitals plan their color styling programs. For the hospital administrator, this has a decided advantage.

Another important trend to consider is the use of accent colors in room interiors. Interiors should be planned, of course, only with the guidance of qualified color and illumination engineering consultants. Among the many methods of gaining correct color accents are the use of the new colored telephones, lamps, incidental pictures, and the judicious use of wallpaper. This latter use of color is becoming more and more important today as a decorating feature; but wallpaper colors and patterns should be carefully chosen to provide restful, not arousing, surroundings.

MAY CAUSE ADVERSE EFFECT

Draperies or wallpapers that are too specific in detail may cause an adverse effect on patients—simply by their concentration on one single theme. Everything in the patient's room—draperies, wallpaper, fabrics—must be chosen with care, precision and a sense of effective coordination. Each item must be the most practical and easily maintained for the hospital staff.

It is significant to note, too, that color-correctness is more important in room decoration than is design. Certain colors and color groupings can make some furniture designs appear larger or smaller, weaker or bolder. Color speaks a universal language. Design exerts no influence over color, however. For example, a square design and a round design in the same red will not appear to differ in color. But, place the two red designs against a background of the exact same red and it will be most difficult even to see them. Change the color of the background against which these designs are viewed, and the character of the red will be altered at will.

Color can also create illusions about size. Dark colors make rooms seem smaller, more exclusive. The reverse psychology has also been used successfully. Lighter colors create an illusion of greater size.

Since hospitals are functional, highly specialized institutions using the most advanced scientific research for the benefit of patients in every detail of building equipment and treatment methods, it is logical to assume that too much attention cannot be given to proper color styling for the welfare and satisfaction of the patients, as well as for the staff.

Color Recommendations for Utilitarian Purposes

Use	Color
Machine frames, beds, horizons, or entire walls forming a background behind equipment.	Green
Aisle floors in certain work areas around equipment.	Light Gray
Horizons, dadoes, or entire walls forming a background, behind equipment, where workers see the walls in looking up from work.	Deep Green
Ceilings to blend in pipes and ducts.	Blue
Aisle borders, setting off distinctive areas, moving equipment.	Deep Yellow
Walls and columns not immediately within the patient's vision since this color simulates sunlight.	Light Yellow
Machine areas adjacent to working points.	Beige
On switch boxes, start and stop buttons, fire fighting equipment, exits, safety devices, danger points.	Red
Working platforms, working bands on traffic lanes.	Orange
Floors where high reflection is not needed, areas under machines.	Dark Gray
Bands on materials handling equipment, stripes at dead ends, turns.	Black

Selecting and Buying Paint

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THERE is a practical way out of the maze and confusion that surround the purchase of paint.

This is the conclusion reached by a special committee appointed in Connecticut to undertake standardization of paints and related products for use by various departments and institutions. The group has been working on the problem for two years with interesting results.

Connecticut's state purchasing division has tentatively adopted the preliminary recommendations of its paint committee and is trying out a new approach in purchase of several paints. The new method seems to offer a dependable way of determining the relative dollar value of several similar paints by comparison of their formulation and certain important qualitative and quantitative characteristics.

MAKEUP OF COMMITTEE

The group studying this problem is well qualified. It includes the supervisors of plant and maintenance of six of Connecticut's largest state institutions (including the University of Connecticut), the director of the State Highway Materials Testing Laboratory, the principal architect of the State Public Works Department, and the painting supervisors of two smaller institutions. Members of this group have an impressive cumulative experience, practical knowledge, and substantial familiarity with a wide variety of general and special purpose materials. Thus far the conclusions of the committee have been surprisingly unanimous.

Publicly advertised bids were requested recently on a substantial quantity of interior and exterior paint. The bid documents contained a partial description of the method to be used to determine the relative value of each product offered. The qualitative and quantitative characteristics indicated that value rather than price alone was the objective sought. Representatives of several reputable companies volunteered agreement with the new approach even though their standard products might not meet the characteristics listed. Little difficulty was experienced in establishing rated values and the awards were made on that basis, also without objection from any of those bidding.

Information was and is being gathered from several sources. That supplied by leading paint manufacturers which was supported by impressive commercial tests was accepted at face value. Data were made available by the State Highway Materials Testing Laboratory. Considerable information was garnered from the files of the maintenance department of the University of Connecticut and other state agencies.

Data supplied by the University of Connecticut were particularly valuable. The maintenance department at that institution does all redecoration in a physical plant of some 300 buildings, including dormitories, educational and athletic facilities, numerous farm buildings of all types and construction, apartments and dwellings. Its paint crew consists of several foremen, glaziers, sign painters, furniture refinishers, and 17 skilled painters. On a year-round basis it is one of the largest "paint contractors" in the state.

The department keeps detailed and accurate records on all of its operations. It does a wide variety of general and special painting, using all generally recognized painting systems. It has employed a large number of the products of a dozen or more manufacturers during the last eight years. The observed results of painting and decorating done as part of the contract construction of 55 new buildings at the university during the last seven years added further information to these sources.

STANDARDS AND SCHEDULES

Good planning requires that operations be defined so as be be reasonably measurable. The establishment of standards and objectives provides a basis for schedules upon which the requirements for manpower and materials can be calculated and anticipated. Some eight years ago the university undertook such a program, and one of the first sets of standards was for painting.

Maintaining student living quarters tops the list of maintenance problems at most, if not all, colleges and universities. This discussion will deal with this phase of painting in considerable detail. The reasoning can be applied to any painting problem.

In 1946 the standard for interior painting of dormitories was established as a two-coat application of a good quality oil paint, complete washing of all sleeping room walls each summer for the next three years, and repainting during the fifth year. Corridors, stairwells and other areas of general use usually get twice as many washings. Although a good oil paint was used, its washability was such that the appearance of most rooms during the fourth year (after the third washing) was not too good. A more durable paint was needed.

The standard was changed in 1948 to a two-coat alkyd resin flat paint. Walls were to be washed once a year for five years (corridors, twice as often) and then repainted, giving a total of six years of service. By 1952 it appeared the six-year standard was practical and that the appearance of the alkyd resin paint would be better than that of shorter lived oil paint.

Research and experiment continued and, in 1953, the standard again was

Above, left: Applying paint with a brush is a slow process. Above, right: Applying paint with spray gun (top of picture). Spray equipment, shown against the wall, is permanently mounted in an old bus, which is not shown here.

revised on the basis of improvements in products offered by several major paint companies. The conclusions were a one-coat, alkyd flat or semigloss paint applied with a roller would meet the requirements previously established for the two-coat alkyd resin. Studies and tests indicate with substantial assurance that the new standard can be met. The roller adds about 15 per cent above the film thickness obtained with a one-coat brush application. Paints now available contain sufficient hiding power in thin, dense, durable films. Manufacturers will warrant not less than eight streak-free washings before repainting is needed.

By establishment of a standard and by systematic research and experiment, dormitory painting costs at the University of Connecticut have been reduced about 40 per cent. What also is important is that it now seems possible to maintain painting standards and schedules in a greatly enlarged plant without increasing manpower.

The odorless, fast-drying "alkyds" have made possible a complete revision of painting schedules at the university. Redecoration of dormitories, offices, classrooms and laboratories is done now only between October 1 and June 15 of each year. This schedule releases the painting crew for work on the exterior of buildings during the late spring, summer and early fall. Previously most painters were working in dormitories during the summer. Under the new arrangement none of the dormitories is out of use at any time during the year. This permits scheduling of the numerous conferences and summer sessions with little restriction on the use of any facility. Classrooms, offices and laboratories are painted at night.

The objective is to get a satisfactory job at the lowest cost. The present percentage ratio between costs of labor and material is 80 to 20. The price of material is important, but the quality of the material is more important as a means of protecting the investment in labor. A saving of 50 cents per gallon in a "500 square-feet-per-gallon paint" amounts to .001 cent per square foot initially and $\frac{.001}{6}$ cent per square foot per year if it lasts six years. If it fails during the fifth year, and repainting is necessary, the cost of that job rises by 20 per cent.

Categorically the failure to meet a painting standard can be compensated for only by a reduction of the standard, by procuring a material that will meet the performance desired, or by additional manpower for more frequent repainting.

QUALITATIVE CHARACTERISTICS

Selection of a paint requires a determination of the properties it must have to perform as expected. The material for interior work presently in use at our institution is described as a one-coat hiding, nonyellowing alkyd resin, self-sealing, odorless, scrubable paint. The following qualitative characteristics describe several of the important requirements.

1. The paint shall have self-sealing features such that one coat of medium color depth on unpainted, dry, smooth plaster shall be capable of yielding a uniform color and appearance without use of a primer or other first coat on the wall. It shall be flexible and shall show easy brushing, good flowing and spreading with good leveling properties. It shall dry to a uniform, smooth, flat appearance free of shiners, flashes and lap marks.

2. Tinted paints shall dry to a uniform color free from streaks and color flotation. Colors shall exhibit excellent resistance to alkali and fading. After application, paint shall show absence of sagging. Lap time shall be sufficient to permit joining of sections without showing lap marks.

3. Paint in unopened containers shall be entirely free of skins, and skins in partially full containers shall be continuous, firm and sufficiently cohesive to be removable all in one piece. The paint shall be ready for application as it comes from the container, except that thinning may be performed as specified by the manu-

(*Continued on Page* 126)

Statistics Ought to Say Something

Pilot project on hospital morbidity reporting proves the value of comprehensive and specific data

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NUMEROUS data of various types are recorded in all hospitals, day in, day out. Much information is routinely recorded in the patients' charts; other data are computed for administrative purposes.

Central agencies on local, state and national levels periodically collect information from hospitals for purposes of consolidated reports. Most statistical reports concentrate on the numbers of hospital beds and of patient days. They serve as basic units for many of the routine computations, such as average daily census, bed occupancy rate, average length of stay, and per diem cost. Some of the questionnaires moreover inquire about personnel of specified types, availability of special facilities, performance of special services, and other organizational as well as fiscal matters.

Most of the information thus collected covers the producer, the hospital; few of the inquiries are concerned about the consumer, the patient. Inquiries regarding patients are mostly limited to the number of admissions and discharges, of births and deaths in hospitals. But no statistics are compiled regarding the medical and demographic data of the patients who receive hospital care.

To be truly meaningful, reports on hospital services would, it seems, have to center on the *patients,* the medical condition that brings them to the hospital, the amount and type of care they receive, and the result of this care; these should be reports on "hospital morbidity."

In New York City, the departments of hospitals and health, with the cooperation of Russell Sage Foundation, have recently conducted a pilot project on the reporting and significance of data on hospital morbidity. This project covered all patients discharged during six consecutive months from all hospitals operated by the New York City Department of Hospitals, amounting to a total of nearly 122,000. Each report included data on medical diagnosis, age, sex, race, length of hospital stay, surgical intervention, and condition on discharge.

Methodology and findings of this pilot project will be described in detail in a forthcoming report.* In the following, a few conclusions as to the usefulness of these data on hospital morbidity are summarized. It should be kept in mind that the patients in New York's municipal hospitals do not represent a cross section of the city's population since these hospitals serve primarily the indigent and medically indigent.

There is a sensitive dearth of information on both "general" morbidity, *i.e.* morbidity-at-large without specification of the conditions involved, and "specific" morbidity, *i.e.* incidence and prevalence of specified diseases. Diagnostic data originating from hospitals are inadequate to fill these gaps; but knowledge on general morbidity would gain substantially from data on people who are sick to such a degree that they are admitted as inpatients.

The main significance of the hospital reporting scheme is in the area of *specified* morbidity. Centrally collected data from all hospitals in a community would provide complete information on the diseases for which people of given demographic characteristics receive inpatient care. Emphasis would be on serious illness and most minor illness would be excluded.

These diagnostic statements from hospital records in conjunction with demographic data would be of value for various public health programs. For health education and case finding efforts—to mention just two public health activities—current information on specified morbidity among known groups of the population might contribute toward prevention of some, and early diagnosis of other, conditions. A few examples may illustrate these points.

ACCIDENT CASES NEED ANALYSIS

Traumatic conditions play, at present, a leading rôle in hospital morbidity. In the New York pilot project, 15 per cent of all hospitalizations, other than those of obstetrical patients, were caused by traumatic conditions; many of these are preventable. Health education concentrates much of its efforts on accident prevention. However, lack of factual data on the occurrence of accident in specified age-sex groups has thus far handicapped such efforts.

Centralized information on injuries is at present limited to those with fatal outcome and those with insurance or compensation aspects. But most of the accidents which occur during household work, at play and sport do not fall into either of these categories. Many of them are admittedly minor and the injured do not need to be hospitalized. However, those patients with traumatic conditions which require hospital care are sufficient in number and in variety to supply acci-

*Morbidity in New York Municipal Hospitals, 1952. Report on a Pilot Project in Hospital Morbidity Reporting. By Marta Fraenkel, M.D., and Carl L. Erhardt. In preparation.

dent prevention measures with revealing leads.

For instance, 3350, or more than 22 per cent, of the patients hospitalized for traumatic conditions were children under 15 years of age. This means that in New York City current morbidity reporting by municipal hospitals alone would have produced within one year combined diagnostic and related data on 6700 accidents among children, all of them of more than trivial nature. Only the 75 of the accidents with fatal outcome would have become known anyhow.

RACE AFFECTS NEOPLASM RATE

Another illustration concerns neoplasms. According to the data of the pilot project nearly 38 per cent of the patients with cancer of the cervix were nonwhite; but only nearly 19 per cent of female patients with malignant neoplasms of other sites were nonwhite. Moreover, more than 75 per cent of the patients with fibromyoma of the uterus were nonwhite as against 42 per cent of female patients with nonmalignant neoplasms of other sites. If comprehensive community-wide hospital reporting would produce similar findings, *i.e.* a disproportionately high frequency of specified neoplasms of the uterus among nonwhite women, then cancer detection and other case searching efforts would have a concrete starting point.

Developments in the epidemiology of tuberculosis are evidence as to what intelligent case finding, health education, and prevention can do if a solid stock of statistical information in which professionally established diagnostic data are combined with demographic and socio-economic data is currently available. The hospital discharge data, incidentally, matched the data on prevalence of tuberculosis in the various demographic groups of New York City as collected and kept to date by the city health department.

In hospital administration, as mentioned before, the basic unit of service is the patient day, *i.e.* "that period of service rendered an inpatient between the census-taking hours on two successive days."

In the analysis and evaluation of hospital services, the diseases for which the days of care are rendered are not considered. Some reports specify the *type* of service involved, by listing separately the patient days rendered on medical, surgical, orthopedic and other services. Data on average length of stay, on per diem cost, and so on are computed on the aggregate of *all* patient days. These over-all figures are used for comparisons of hospitals of the same type, say, general hospitals. Reduction in the average stay is often considered as reflection of increased efficiency of hospital administration or of increased efficacy of medical care, or as the result of the newer therapeutic methods.

How significant are statistics based on the unspecific unit of a patient day? Do they supply the hospital administrator with the type of information which he needs for operation and planning of his institution? Analyses of the pertinent data from 14 municipal general hospitals in the aforementioned pilot project have shown convincingly the limited meaning of unspecific length of stay data. These 14 hospitals are of the same type of service, namely, general; they operate under the same control, namely, the department of hospitals, which determines the uniform admission policy and passes on uniform procedures and standards of care. These factors might *a priori* suggest uniformity in program and, hence, comparability of data on services rendered.

The average length of stay in these hospitals ranged from less than 11 to more than 28 days.

A range of this magnitude cannot be a reflection of different degrees of achievement in medical care or administrative skill. Other, more basic factors must be influential. The major cause for the substantial difference in length of stay is the considerable difference in the composition by disease of the patient load of these various municipal general hospitals.

STAY IS "DISEASE-SPECIFIC"

The proportion of obstetrical patients, for instance, varied from 9 to 25 per cent of all discharges. Delivery is notoriously a short-stay condition. As many as 82 per cent of the women were discharged after less than seven days of hospital stay; this includes 12 per cent who were discharged within three days. The relative size of this one diagnostic group within the total patient load of a hospital may basically influence the average length of stay of the hospital as a whole. This is demonstrated, for instance, by the following data: In one of the hospitals where deliveries accounted for less than 10 per cent of the total discharges, the average stay was as high as 23.2 days, whereas in another hospital where deliveries accounted for 25 per cent, the average stay was less than 11 days.

Average length of stay data for patients with given diseases, what might be called "disease-specific" stay data, can be of major significance for hospital administration. If the duration of patients with a given condition, such as maternity cases, varies markedly among hospitals, then examination as to the underlying causes is indicated; a variety of influencing factors may be revealed.

In two of the municipal hospitals the length of stay of obstetrical patients was found considerably below average. In both of these hospitals sizable proportions of women, namely, 25 and 33 per cent respectively, left the hospital after less than four days. The obstetrical services of these two hospitals accommodate a large number of women of specific demographic and socio-economic features. In view of their domestic responsibilities, these young women are not willing to remain in the hospital as soon as they are physically able to be up and about. They "sign themselves out" after three, sometimes even two, days of postpartal care.

Cognizance of an accumulation of such early discharges is important to hospital administrators, to take necessary action. In this instance, follow-up visits by public health nurses and intensified programs in the postpartum clinics were initiated.

DEATH RATE ISN'T A CRITERION

One wonders why in their routine statistics hospitals use "averages" to describe the length of stay rather than classify the durations of discharged patients according to significant categories. For many, if not most, patients, care during the first days in a hospital is particularly active; the patients require intensive medical and nursing care and extensive laboratory and other services. The per diem cost thus is very high. On the other hand, care during protracted stays often decreases in volume and complexity. The per diem costs in later phases are accordingly lower. For considerations of this type, classification of hospital stays by significant categories of duration would, it seems, be much more informative than the nondescriptive "average."

Another widely used yardstick in hospital administration is the death rate. Even in its refined form of "net

death rate" which excludes all deaths occurring within 48 hours after admission, the rate seems too unspecific for conclusive evaluation of a hospital's performance and inappropriate for comparison among hospitals.

The net death rates in the 14 municipal general hospitals ranged from 1.6 to 10.6. Again, such a wide range cannot be solely the reflection of qualitative differences but must be caused by basic differences in the patient loads of the hospitals involved.

The *age* composition of the hospitals' populations was found to vary widely. The hospital with the lowest death rate, 1.6, had the youngest population; only 4.5 per cent of its discharges were 65 years of age and over. The two general hospitals with the highest death rates, namely, 8.9 and 10.6, respectively, were, on the other hand, the "oldest" hospitals. In either of them, approximately 26 per cent of the discharges were aged persons. If computed for specific age groups, the picture of the widely different death rates loses some of its diversity.

But it is the composition of the patient load by *diagnosis* which has the most decisive influence on the death rate in a hospital. A single condition with a distinctive rate can, if numerically significant, basically influence the death rate of the institution as a whole. Women hospitalized for delivery notoriously account for virtually no deaths. The net death rate in a hospital in which 25 per cent of the discharges are deliveries is, therefore, *a priori* relatively low. Comparisons of its death rate with those of general hospitals where only 8 or 10 per cent of the discharges were women with this nonfatal condition are, therefore, unsound.

DATA FOR COMMUNITY PLANNING

The significance of current hospital morbidity data for community planning is mainly in the areas of master planning for hospital care and for comprehensive integrated medical care programs, of which hospitals are important elements.

Master planning for hospital facilities is a relatively new science which has developed conspicuously within a few years. This successful development is the more remarkable since the facts and figures which have thus far been available for such planning are not adequate. They consist mainly of vital statistics data on deaths by cause and of hospital data on admissions, beds, patients days, and such derivatives as occupancy rates. The Hospital Council of Greater New York, New York City's voluntary planning and coordinating agency in this field, stated some time ago editorially (*Bulletin* of February 1952): "For purposes of hospital planning geared to meet not only present but future requirements of the population, there is urgent need for a reliable standardized system of reporting on the incidence and trends of all diseases and conditions responsible for the hospitalization of nearly one million persons in New York City annually."

Two examples chosen out of a wealth of material from the pilot project may demonstrate the use of current hospital morbidity data for community planning. They are illustrative rather than representative.

TWO ILLUSTRATIONS

Slightly more than 16 per cent of all patients discharged from the municipal hospitals were aged, 65 years and over. There were nearly 28 discharges from municipal hospitals per 1000 persons of 65 to 74 years of age in New York City, and 46 per 1000 persons 75 years and over. The corresponding rate for all ages was 15.5. These quantitative aspects are of major concern for medical care planning in communities with rapidly aging population.

Aged people are hospitalized for the whole gamut of diseases, with the exception, of course, of conditions specific for the younger age brackets. But a few diseases are characteristic and others are particularly important for old age, either because of frequency or seriousness or both. Among the conditions found among more than 50 per cent of the patients 65 years and over were, in addition to senility and senile psychosis, vascular lesions of the central nervous system, general arteriosclerosis, hyperplasia of the prostate, arteriosclerotic and degenerative heart disease, and cataract.

For medical care planning it is important to know the rôle of given diseases in the morbidity of aged people. Arteriosclerotic and degenerative heart disease was found at the top of the list. Nearly 13 per cent of all aged patients were hospitalized for this condition; more than 10 per cent were hospitalized for malignant neoplasms. Surgery extends its services by now to old and very old persons. Of the aged patients with hyperplasia of the prostate, 66 per cent were operated on while in the hospital, and 56 per cent of the aged patients hospitalized for hernia underwent an operation.

Community planning of integrated medical care for the chronically ill is equally in need of current hospital morbidity data. Many patients with chronic diseases are at various phases of their illness in need of various types of care. Periods of well-being may alternate with periods of infirmity, either of which may be interrupted by attacks of acute exacerbation. Only a varifold, well integrated medical care program can adequately cope with the kaleidoscopic picture of chronic disease.

Hospitals, especially general hospitals, are an important element in the chain of services needed. Short hospital stays are a frequent feature in the long-term care of patients with chronic diseases. Current hospital morbidity data should guide the planning for extra-hospital facilities and services. Some data on hypertension, as a typical chronic condition in which periods of quiescence are not infrequently interrupted by attacks of acute exacerbation, may illustrate this point.

DISCHARGES OFTEN CONTINGENT

Thirty-three per cent of the patients with hypertension were discharged after less than seven days of hospital care. Even after eliminating the early hospital deaths, the fact remains that more than 29 per cent of the hypertension patients who were discharged alive left the hospital within six days after admission. These patients, just as those with some of the other classic chronic diseases, can be discharged from hospital care as soon as the acute attack is over *if* the community provides adequate facilities and services for their follow-up care. Such care may be in the patient's own home provided physicians, visiting nurses, housekeeping aides, and other needed services are available, or in institutions of nursing, custodial or related types of care.

Planning of such complex and integrated programs should be based on factual knowledge of the clinical characteristics and the medical care needs of the patients, their needs for care in times of quiescence as well as during episodes of exacerbation of their chronic illness.

The variety of elements that determine the need for medical care is so large that comprehensive, specific and up-to-date data are needed as beacons to guide a community's steps.

After reviewing the problems presented by the layout of the existing department at Rockford Memorial Hospital, Rockford, Ill., experts from the sterilizer industry offer

Two Solutions to a Central Supply Problem

IN THE "Design Postmortem" on Rockford Memorial Hospital, Rockford, Ill., which was described in the March issue of The MODERN HOSPITAL, it was brought out that the only department which showed serious faults from the operations standpoint was central sterile supply. Plans of the existing department were referred to consultants in the sterilizer industry with a request for recommendations for improving the layout.

Following are the consultants' suggestions for a preferred plan (Drawing A) and their review of the plan as it is presently (Drawing B), with suggestions for rearrangement of equipment which would make it at least practical though admittedly not the best solution to the problem.

These plans and comments have been referred to John Brown, administrator of the hospital, who said, "I take no real exception to anything suggested here except the recommendations concerning the manufacture of solutions. With the personnel available to the average hospital of our size, I simply refuse to accept the responsibility of making our own intravenous solutions; I just don't think it is wise. I guess I also lean toward not supplying floor stocks of sterile dressings and allied materials to the various patient units, but rather prefer to issue almost everything on a requisition basis for individual patients. I have had the sad experience of seeing thousands of dollars worth of such things (and drugs) used up without any suitable charge being placed on the patient's account."

DRAWING A

DRAWING A shows what we believe to be the preferred plan for the area involved. The main reason for the design of this plan is that we believe that when there is only one dumb-waiter it should be on the sterile storage end of the department and it will be noted that we have the dispensing door located in that area and the receiving door off the corridor on the other side of the elevators and the stairs.

Just inside the receiving door is the general clean-up section for general equipment. That equipment goes from there to the clean work area, to the sterilizers, to the sterile storage area where it can be dispensed through the dispensing door or by the dumb-waiter and there is no backtracking in the flow of materials.

The glove room is located near the receiving and clean-up area so that dirty gloves can be received at the receiving door, taken directly to the glove room where they will be washed, dried, tested, powdered and wrapped; from there they will go to the sterilizers and on to the sterile storage; then they will be dispensed through the dispensing door or the dumb-waiter without backtracking.

The solution, distilled water, needle and syringe room is so located that unclean flasks, needles and syringes can be received at the receiving door but go directly to this room in which unclean flasks and closures, as well as needles and syringes, will be cleaned and where intravenous and external solutions are prepared and needles and syringes are processed. From there, all of this equipment goes directly to the sterilizers, then to the sterile storage area where it will be dispensed through the dispensing door or the dumb-waiter. Again there is no backtracking in the flow of materials.

We recommend that a hospital of this size, since it must have a sanitary room for making external, external irrigating, and surgical fluids, as well as for needles and syringes, make their own intravenous solutions. The technician in charge of this room should be responsible to the central sterile supply department supervisor during the processing of syringes and needles but should be under the supervision of the pharmacist during the making of solutions.

We feel that this is an excellent plan for the area available. However,

if another 250 or 300 square feet were available, the department would be more efficient, for then the hospital could have its unsterile equipment room with Wangensteen's gas evacuators, resuscitators and similar equipment restored here, under control of the central supply supervisor.

The adjacent milk formula laboratory is so laid out that there is complete segregation between the clean-up area and the preparation room and everything that comes into the clean-up room is completely sterilized before it enters the preparation room section.

It must be kept in mind that the purpose of the modern milk formula laboratory is to protect well infants from infected infants and the only means of doing that, as far as the laboratory itself is concerned, is to make sure that nothing comes into the preparation room from the clean-up room (we consider everything in the clean-up room contaminated) unless it is sterilized before it enters the preparation room.

DRAWING B

DRAWING B on page 80 shows this department with all of the partitions left as the department now stands, with sterilizers in the same location, and so forth.

We took the liberty in this plan of rearranging the receiving and dispensing doors with a glass partition added which would divide the receiving and clean-up area from the sterile storage area.

We have left the sterilizers in exactly the same location as they are now located at the hospital; we have merely rearranged some of the equipment and while we have not been able to have a glove room, we have taken advantage of the area next to one sterilizer section to show a glove washer, glove conditioner, and the necessary glove counter space. While this glove area is in front of the large sterilizer, we believe it is far enough away so that the loading carriage will not interfere with work going on in the glove section, or vice versa, and it must be kept in mind that the sterilizer carriage is only pulled out for loading.

What we don't like about this plan is that the dumb-waiter must be used for both receiving and dispensing as it was not possible to put either one of those doors in the same location we showed on the other plan because the sterilizers surrounding that area

DRAWING A

EQUIPMENT LEGEND—DRAWING A

1. Unclean Equip. Counter—3 Open Shelves Under.
2. Washing Sink.
3. Rinsing Sink.
4. Clean Equip. Counter—Cabinets Under.
5. 24"x36" Portable Double Deck Cart.
6. Glove Washer.
7. Glove Conditioner.
8. Work Counter—Open Under.
9. Work Counter—Drawers & Cabinets Under.
10. Recording Conductivity Meter.
11. 10 Gal. per Hr. Water Still With 12 Gal. Storage Bottle.
12. Portable Flask Washer.
13. Portable Syringe Washer.
14. Needle Cleaner.
15. Worktable—Open Under.
16. Double Hot Plate.
17. Grilled Sink.
18. A.S.P.F. Safety Filler.
19. Concentrate Bottle.
20. Pressure-Vacuum Control Panel.
21. Overhead Wall Cabinet.
22. Supervisor's Desk.
23. Work Counter—Cabinets Under.
24. Unsterile Storage Cabinet—6'0" High With Glass Doors.
25. 4'x8' Worktable—Bins on Top, Tilting Bins Under.
26. 4'x8' Flat Top Worktable.
27. 20"x20"x36" Surgical Supply Sterilizer.
28. 24"x36"x48" Surgical Supply Sterilizer.
29. Model No. 821 Hot Air Sterilizer.
30. Sterile Storage Cabinet—6'0" High With Glass Doors.
31. Sterile Storage Cabinet—6'0" High—Open Shelving.
32. Records Counter—10 Drawers Under.
33. Bottle Washer.
34. Bottle Rinser.
35. Clean Equip. Counter—3 Open Shelves Under.
36. 20"x20"x36" Formula Sterilizer.
37. 10 Gal. Water Sterilizer.
38. Shelf.
39. Scrub Sink.
40. Chair.
41. 2'x5' Worktable.
42. 6 Cu. Ft. Refrigerator for Ingredient Storage Only.

Drawings, courtesy of American Sterilizer Co., Erie, Pa.

Drawing A, preferred by the experts, entails a redesign of the department to eliminate backtracking of materials.

would not allow us to show the necessary sterile storage.

By locating the dispensing and receiving doors as we have in this room, we do have the receiving area adjacent to the receiving door and the sterile storage area adjacent to the dispensing door. The sterilizers work out satisfactorily in that location because one of the fundamental rules in laying out a central sterile supply department is that the sterilizers must be the last step before the sterile storage area.

Another undesirable feature in this plan is that the dirty gloves and the dirty flasks, needles and syringes, of necessity, must go through the clean work area to get to their washing and preparation station.

We have used the present walls to house a solution, distilled water, needle and syringe room and we are utilizing the present still for the clean-up side of this room and, of course, recommending a new still on the preparation side.

There is no question that there will be more powder from the glove processing throughout this room than there would be in the other plan even though a glove conditioner is shown in the plan. Gloves should be washed and prepared in a room by themselves.

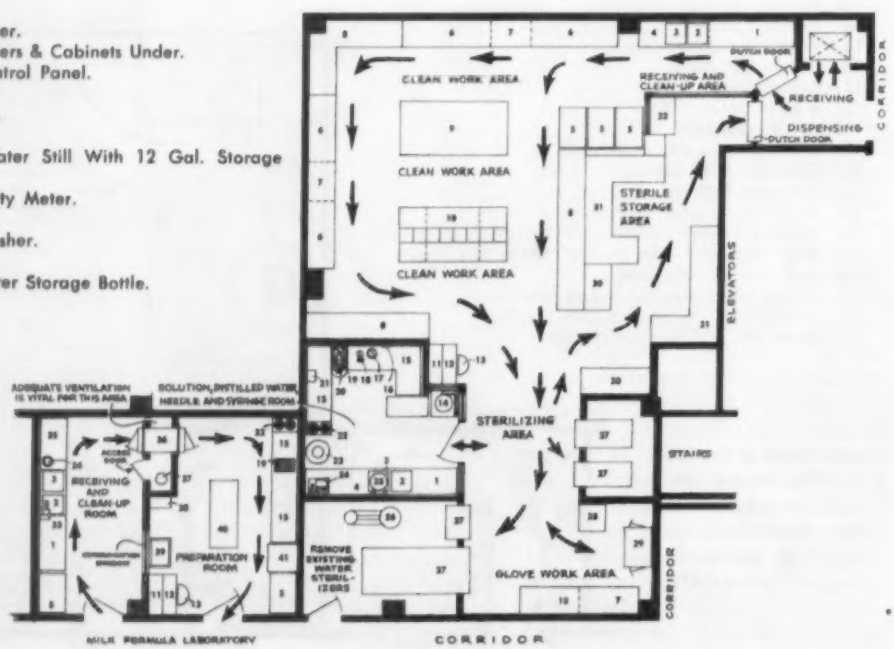
This plan, also like the other one, is 250 to 300 square feet short of the proper area required; therefore, it is not possible to have an unsterile equipment storage area so that that equipment could be under the control of the central sterile supply department supervisor.

Our comments regarding the milk formula laboratory would, of course, be the same as those we made for the preferred plan. In addition, we feel that the technic in that department is of such importance in order to give infants proper protection that we do not believe sterilizers from another department should ever be used for the milk formula laboratory. Formula preparation employes, who are gowned, capped and masked, should not have to leave that laboratory to sterilize their equipment or to heat-treat the formulas after they are processed, and it must be kept in mind that many formulas cannot be heat-treated. Therefore, whether the hospital likes it or not, the personnel must be kept gowned and masked and a sterile technic must be carried out for those formulas. This makes it imperative that, regardless of the kind of formulas being prepared, the equipment should be sterilized and the formulas that can be heat-treated should be treated within the department so that the entire function of the milk formula laboratory is carried out within its own walls.

DRAWING B

EQUIPMENT LEGEND—DRAWING B

1. Unclean Equip. Counter—3 Open Shelves Under.
2. Washing Sink.
3. Rinsing Sink.
4. Clean Equip. Counter—Cabinets Under.
5. 24"x36" Portable Double Deck Cart.
6. Work Counter—Cabinets Under.
7. Work Counter—Open Under.
8. Unsterile Storage Cabinet—6'0" High With Glass Doors.
9. 4'x8' Flat Top Worktable.
10. 4'x8' Worktable-Bins on Top, Tilting Bins Under.
11. Overhead Wall Cabinet.
12. Supervisor's Desk.
13. Chair.
14. Portable Flask Washer.
15. Work Counter—Drawers & Cabinets Under.
16. Pressure-Vacuum Control Panel.
17. Concentrate Bottle.
18. A.S.P.F. Safety Filler.
19. Grilled Sink.
20. 10 Gal. per Hr. Water Still With 12 Gal. Storage Bottle.
21. Recording Conductivity Meter.
22. Double Hot Plate.
23. Portable Syringe Washer.
24. Needle Cleaner.
25. 12 Gal. Distilled Water Storage Bottle.
26. Existing Water Still.
27. Existing Sterilizer.
28. Glove Washer.
29. Glove Conditioner.
30. Sterile Storage Cabinet—6'0" High With Glass Doors.
31. Sterile Storage Cabinet—6'0" High—Open Shelving.
32. Records Counter—10 Drawers Under.
33. Bottle Washer.
34. Bottle Rinser.
35. Clean Equip. Counter—3 Open Shelves Under.
36. 20"x20"x36" Formula Sterilizer.
37. 10 Gal. Water Sterilizer.
38. Shelf.
39. Scrub Sink.
40. 2'x5' Worktable.
41. 6 Cu. Ft. Refrigerator for Ingredient Storage Only.



Drawing B shows the existing layout but with some rearrangement of equipment. It is not ideal but is an improvement.

Does It Pay to Be Director of Nurses?

Report on a survey of salaries paid to nursing directors in hospitals ranging from 200 to 1000 beds

LEWIS B. PERRY Jr.
Personnel Officer, University of California Medical Center, San Francisco

B. S. KAISER
Chief Personnel Officer, University of California, San Francisco

IN OCTOBER 1953, the University of California personnel office, under the direction of B. S. Kaiser, chief personnel officer, made a nationwide survey of salaries paid in selected hospitals for the position of director of nursing service. Because of intramural considerations, the survey was aimed at developing salary data for the type of position that is exclusively concerned with hospital nursing service under administrative direction, rather than for the type of position concerned with both hospital nursing service and school of nursing functions. Since only selected teaching hospitals were surveyed, data on both kinds of positions were obtained and are reported in this paper.

SCOPE OF THE SURVEY

Standards adopted for the selection of the sample were these:

1. The hospitals are located in cities where medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association are located.[1]

[1] Hospitals, Administrators Guide Issue, June 1953, Part II, pp. 292-293.

2. They are part of or affiliated with medical schools.[2]

3. They are in the size range of 200-1000 beds.

4. They are both private and public, but no hospitals operated by the U.S. government are included.

5. They are non-Catholic.[3]

Questionnaires were sent to all of the 114 hospitals throughout the country that met these standards. Replies were received from 101, with 92 containing salary information.

COMBINED SCHOOL AND SERVICE

In 54 hospitals giving salary information, the educational and service functions are correlated by a director having dual responsibility for both.

Some institutions have formal salary ranges for the director and reported both minimum and maximum of the range.[4] Others reported only a single rate currently being paid. The arithmetical midpoint of the ranges were combined with the single rates to compute what is called here the "dollar midpoint."

In order to make allowance for area differentials and also hospital size differentials, the hospitals were also asked to report the salary range or rate for staff or registered nurse, the entry level class in the nursing profession.

Table 1—Annual Salaries in Hospitals With Combined School and Service

Hospital bed size	200-400	401-600	601-1000	200-1000
Number reporting	25	19	10	54
Dollar midpoint, director of nursing mean	$5895	$6375	$6214	$6123
Median	$5574	$6450	$6463	$6000
Interquartile range	$5280-6687	$5712-7000	$5465-6842	$5394-7000
Per cent of dollar midpoint, director of nursing, relative to dollar midpoint, staff nurse mean	203.5%	210.5%	200.5%	205.4%
Median	199.1	210.4	201.5	199.5
Interquartile range	172.3-211.9	185.5-236.9	176.2-227.5	178.9-227.5

Table 2—Annual Salaries in Hospitals With Separated School and Service

Hospital bed size	200-400	401-600	601-1000	200-1000
Number reporting	11	16	11	38
Dollar midpoint, director of nursing mean	$5514	$6054	$6004	$5883
Median	$5750	$5766	$6000	$5773
Interquartile range	$5788-6083	$5300-7000	$5399-6700	$4855-6700
Per cent of dollar midpoint, director of nursing, relative to dollar midpoint, staff nurse mean	187.0%	193.0%	196.1%	192.1%
Median	179.8	193.6	196.3	188.4
Interquartile range	161.8-208.9	175.6-204.6	175.0-222.7	168.2-215.2

[2] Ibid., pp. 49-207, coded A-5.

[3] Catholic hospitals were excluded for the reason of nonsalaried positions of director of nursing service.

[4] Cash salaries only were reported in 41 cases. Perquisites granted in addition to cash were reported in 13 cases, without specific values. Therefore no attempt was made to convert from the cash to the gross basis.

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In each case the dollar midpoint of the staff nurse range was computed on a 40 hour basis. Finally the per cent of the director's dollar midpoint relative to the staff nurse's dollar midpoint was computed to indicate the spread from top to bottom in the nursing service in each institution.

The replies are summarized in Table 1, grouped by hospital size. Area groupings were also made, within each size group, for example, New England states, 200-400 beds, but in almost all such area groups there were too few hospitals for the results to be significant.

Size of the hospital appears to influence compensation, as measured in dollars, between the range of 200-400 beds and 401-1000 beds. The director of nursing service in a hospital with 401-1000 beds might expect to earn at least $900 more per year than her counterpart in a hospital with 200-400 beds. In terms of compensation relative to the staff nurse in her hospital, the director of nursing service at the dollar midpoint of her range might expect to earn at least twice as much (200 per cent) as the staff nurse at the dollar midpoint of her range. If the director is situated in a hospital with 401-600 beds, apparently her expectations are somewhat better (210 per cent of the staff nurse) than the average.

In 38 hospitals giving salary information, the educational and service functions are administratively separate, with the director of nursing service responsible to the hospital administration for hospital nursing service only. The same method of analysis described heretofore was applied to the reported data, and the results are summarized in Table 2.[5]

Again, size of the hospital appears to influence compensation, as measured in dollars, between the range 200-400 beds and 401-1000 beds. Although the median dollar midpoint for 601-1000 beds is approximately $250 higher than for 200-400 and 401-600, the mean and the interquartile range indicate greater similarity between 401-600 and 601-1000 than between 200-400 and 401-600. Actually the dollar differences are rather small.

In terms of compensation relative to the staff nurse, the director of nursing service at the dollar midpoint of her range might expect to earn at least 180 per cent as much as the staff nurse at the dollar midpoint of her range, in the same institution. The director of nursing service in the 401-600 range might expect to earn somewhat more (15 per cent more of the staff nurses' dollar midpoint) than in the 200-400 range and just as much as in the 601-1000 range.

Every teaching hospital has its own peculiar financial and personnel circumstances that affect the compensation of professional nurses, from the bottom to the top of the service. Differences in size (which affect the scope and complexity of work) and differences in geographical location also affect compensation. Also no hospital and no director wants to be "below average." Despite all these variables, there does seem to be sufficient similarity of compensation for the director of nursing service in hospitals of approximately the same characteristics throughout the country to form a reasonably good yardstick by which to measure fair compensation. A hospital striving to achieve high quality nursing care would seem justified in aiming at fair compensation for its director of nursing service with the nationwide average as a minimum.

[5] Perquisites were reported in only three cases without specific values, and were ignored.

The Nurse Is the Chaplain's Ally

REV. GRANGER E. WESTBERG
Chaplain, University of Chicago Clinics

DURING my more than 10 years' experience as a hospital chaplain I have found the nurse to be exceedingly helpful to me in my work. I know that this feeling is general among all hospital chaplains. We think of two things in particular that she does which not only aid the chaplain in his work but which also contribute to her total effectiveness as a nurse.

First, the nurse is helpful in pointing out to the chaplain those patients in the hospital who need the kind of help he can give. (This presupposes that she knows something about the kind of work which the chaplain does.) Second, the present-day nurse is demonstrating increasing concern for those patients who are going through "inner struggles" which are intimately related to the physical symptoms they display. By talking* to them in ways that fit naturally into the nurse's sickroom conversation, she creates in the patient a desire to want to talk to a minister about these matters.

The mature nurse is aware that percentage-wise there is more solid thinking going on within the walls of a hospital than within the walls of any other building in the community, including the near-by college. Most of us are quite superficial in our thinking until something comes along in the nature of a crisis which forces us to think deep thoughts. Almost everyone who comes into the hospital has been forced to come there because of something over which he literally had no power. The fact that he now finds himself in a hospital bed, unable to do the things he normally does, means that his usual routine has been completely disrupted. For many patients this is the first time in months or even years that they are all alone with themselves. For more people than we care to admit this is not only a new experience but also a very frightening one. The pace of today's living leaves almost no time at all for one to get to "know thyself." The only way that most of us will hold still long enough to take an inner look is to find ourselves in a hospital room and ordered to stay there for a week or more.

Because a hospital chaplain spends the majority of his time conversing with individual patients, he knows that much more happens to people in hospitals than is written on the patient's chart. As one patient put it, "When I went into the hospital, I hadn't the slightest idea that I was going to have a 'spiritual checkup' along with my physical checkup.

(*Continued Opposite Page* 137)

*Chaplain Westberg has spelled out in detail the kind of "talking" he approves in a book being published this month for nurses entitled "Nurse, Pastor and Patient." Rock Island, Ill.: Augustana Press.

Administrators


Horace Turner

Harry Wheeler, administrator of Deaconess Hospital, Billings, Mont., has been appointed administrator of Deaconess Hospital, Spokane, Wash., succeeding **Horace Turner,** administrator there for the last 16 years, who is retiring June 30. Mr. Turner had been administrator of Deaconess Hospital, Great Falls, Mont., before going to Spokane. He is a trustee of the Washington State Hospital Association and past president of the association. He is a past president of the Association of Western Hospitals. Mr. Turner is a fellow of the American College of Hospital Administrators and for several years has served on the standards, surveys and personnel committees of the national Methodist Board of Hospitals and Homes.

Dr. E. A. Baber, who has been superintendent of Longview Hospital, Cincinnati, for the last 32 years, has announced his retirement effective June 30. Dr. Baber entered mental health work at Dayton State Hospital, Dayton, Ohio, soon after his graduation from the University of Louisville and became superintendent there two years later.

Mary R. Hanna has been appointed administrator of Children's Mercy Hospital, Kansas City, Mo., succeeding **Elizabeth Martin,** who has become superintendent of Blosser Home for Crippled Children, Marshall, Mo.

Charles W. Wilson, administrator of Clark County Hospital, Arkadelphia, Ark., has been named administrator of the new Hempstead County Hospital, Columbus, Ark., which will open June 1.

Frank E. Kimble, former administrator of Hardy Wilson Memorial Hospital, Hazelhurst, Miss., has assumed his duties as superintendent of the Denver & Rio Grande Western Hospital, Salida, Colo., succeeding **Norma Clare,** who has resigned.

Ernest C. McKay, administrator of Tampa Municipal Hospital, Tampa, Fla., has resigned. At the same time it was announced that **Arthur G. Burns** has been appointed assistant superintendent there.

Oca Cushman, who has been superintendent of Children's Hospital, Denver, since the hospital was established 45 years ago, has retired at the age of 85. A graduate from St. Luke's Hospital School of Nursing, Denver, Mrs. Cushman joined the staff of St. Luke's in 1903. In 1906 she became identified with the Children's Hospital movement and when the hospital was opened in 1910 became its first superintendent of nurses. Besides heading the nursing service, Mrs. Cushman was for a few years housekeeper and helped with cooking and sewing, as well as seeking funds for the hospital. From 1920 to 1922, she served as president of the Colorado State Nurses' Association.

Kenneth K. Atkins has been appointed business administrator of Anna State Hospital, Anna, Ill. A graduate of the University of Chicago course in hospital administration, Mr. Atkins was administrator of Bethesda Hospital, Crookston, Minn., before going to Anna.

Maj. Gen. George Ellis Armstrong, surgeon general of the U.S. Army, has been named vice chancellor for medical affairs at New York University, following his retirement from the army in July. **Dr. Donal Sheehan,** associate director of New York University-Bellevue Medical Center, has been acting director since the resignation in March 1953 of **Edwin A. Salmon.** General Armstrong is a fellow of the American Medical Association, of the American College of Physicians, and of the American College of Surgeons.

Hazel Croom has been appointed administrator of George County Hospital, Lucedale, Miss., succeeding **Cyrus E. Eaves,** who has become associated with a surgical instrument company in Mobile, Ala.

Lloyd G. Thompson, superintendent of the State Training School, Mandan, N.D., is now administrator of Mandan Community Hospital, Mandan. A graduate of Dakota Wesleyan University, Mr. Thompson has taken postgraduate studies at the University of Chicago, the University of California, Columbia University, and the University of North Dakota.


Oscar M. Marvin Jr.

Oscar M. Marvin Jr., assistant administrator of City Memorial Hospital, Winston-Salem, N.C., since 1953, has been appointed assistant hospital administrative consultant for the North Carolina Medical Care Commission, Raleigh, N.C. Mr. Marvin is a graduate in hospital administration from the University of Chicago. He is president of the North Carolina Chapter of the American Association of Hospital Accountants, a member of the American Hospital Association, and a nominee of the American College of Hospital Administrators.

Samuel K. Hunt, administrator of Memorial Mission Hospital of Western North Carolina, Asheville, N.C., has announced his retirement, effective July 1. Previous to his position at Memorial Mission Hospital, Mr. Hunt had been administrator of Methodist Hospital, Pikeville, Ky., and of Grace Hospital, Morgantown, N.C. Mr. Hunt is a past president of the North Carolina Hospital Association and for the last four years has been representative of the state hospital association to the house of delegates of the American Hospital Association.

W. W. Lowrance, administrator of Self Memorial Hospital, Greenwood, S.C., has been appointed to succeed Mr. Hunt. Mr. Lowrance received training in hospital administration at Duke University and has served as administrator of Cherokee County Hospital, Gaffney, and Tuomey Hospital, Sumter, both in South Carolina. He is a member of the American College of Hospital Administrators, of the American Hospital Association, and the Hospital Advisory Council of the South Carolina State Board of Health.

Charles J. Greene, former administrative assistant in charge of personnel and purchasing of Provident Hospital, Chicago, has assumed his duties as superintendent of Norfolk Community Hospital, Norfolk, Va., succeeding **W. T. Mason,** who has been administrator at Norfolk Hospital for the last

(*Continued on Page* 178)

Two Problems in Press Relations

1—Reporters to the Rescue in Polio Crisis

LYDIA BICKFORD
Public Relations Consultant
Morristown Memorial Hospital, Morristown, N.J.

NEWS, even in hospitals, has a way of breaking unpredictably whenever it feels like it. Here at Morristown Memorial Hospital, Morristown, N. J., our most important and exciting stories have a strong tendency to pop up over a week end. This was the case during a recent crisis: the urgent need for polio nurses to cope with a sudden influx of cases from all over our service area. Expert handling of the situation by our various news agencies was an example of the kind of enthusiastic cooperation that can exist between hospital publicist and reporter.

The incidence of polio ran late into the fall at Memorial, and the last week of October, just prior to the general election, saw us with a peak load—and a shortage of nurses. Fourteen cases demanded attention. Special duty nurses were needed for two patients in iron lungs. Six additional floor nurses were required, and more polio emergency volunteers were badly needed to help in giving the hot pack treatments to patients.

On a Friday night, I was asked to rush out a quick story on our problems. This was four days before election, with a headline-consuming contest on for United States Senator, along with a hot two-party tussle for local mayor. In news terms, the election was everything, and had top priority.

I telephoned the story to the two dailies and one radio station covering the Morristown area—with an introductory speech acknowledging their jam-packed news condition. They said they'd do what they could.

They did—and more. The plea for nurses went out every hour following the five-minute news broadcast. Both papers front-paged the call for help.

Saturday morning I was on the telephone again, calling the AP and UP at their Newark bureaus, reframing the story to read that the hospital had issued a statewide call for nurses. In so doing, I realized I would probably receive calls from reporters, asking if we had an epidemic.

I did: "If you're desperate for nurses, if you have a peak load in the polio wing, don't you have an epidemic? Why can't you get nurses in your area?" Answer No. 1: Not an epidemic, more light cases than before, more awareness on the part of doctors who now diagnosed polio early. Answer No. 2: Many former nurses with families are afraid of polio.

Let's work on No. 2, said the *Newark News* reporter. How about a statement from your hospital director? We tried to roll answers one and two into the same five-sentence package: "Terming the current excitement over polio as hysterical and ridiculous, Director Robert Boyd stated there was no epidemic at Memorial."

The strong statements assailing hysteria were needed in a hurry. Outlying towns which had three or four polio cases were considering closing the movies, barring Hallowe'en parties, and even football games—without regard for the facts: fewer cases per town than in previous years. One town even had a mass gamma globulin injection of all school children, even though the incidence of polio did not warrant it.

Call us back if you get any nurses, said the reporters. We did, and I did. One nurse heard the radio plea while she was on leave from a west Jersey hospital, called our hospital, and was on duty that afternoon. Two more nurses appeared, thanks to pleas by telephone from our director to the administrators of other hospitals.

Then a polio emergency volunteer called the hospital, in a state of great excitement, to say she was receiving anonymous telephone calls threatening her if she didn't stop working with our polio patients. She was being branded as a carrier. Her children were not welcome in school. The drugstore refused to sell her a soda.

This was rough. The whole polio volunteer program was threatened, at a time when we were trying to start a new class of volunteers. The "unwarranted hysteria" was real. The patient in question, with whom this volunteer had worked, also had a daughter in the polio wing as a patient. I could see not only the volunteer but the patient's family branded as carriers in their home community.

Actually, they had already been. A weekly newspaper in the patient's home community had written an appalling and completely uninformed story, charting the activities of our patient before she was diagnosed as a polio case, stating how many people she had already infected, "including some expectant mothers," and winding up with a quote from an ignorant but evidently publicity-crazy official who stated that polio was definitely transmitted by a carrier, and only by a carrier.

This needed quick action, but careful action. It was the time to do something of a public education job, to try to dispel the fear that is associated with polio, and spread the true story.

The decision was to have a conference Sunday with the chief of the medical staff and the head of the polio service, plus the hospital director and myself. Out of it came a three-page news story, hard-hitting, nailing the Dark Ages approach that had caused the spread of rumors, telling the story of polio's inception, and explaining the

treatment. It was really a two-part story, with the medical chief's statement pinning the rumor-mongers with clear-cut remarks like, "To incite unwarranted fear is to court disaster. Most of us are immune to polio." The doctor heading the polio work threw the rumors for a loss, saying, "None of the 70 polio cases treated this year can be traced to contact with another polio case. Those properly trained in polio care do not contract, and have never been known here at Memorial to carry, the disease."

The results of the conference were beyond our wildest dreams: a day before election, three-column, front page story in the *Morristown Daily Record,* printing the statement verbatim, followed by a front-page editorial on election day. The *Newark Evening News* also ran our story the day before election, also in three columns.

Radio station WMTR suggested we make a tape recording, not more than five minutes long, and rush it to the station to be played the day after election. The hospital statement was boiled down, cut into three parts, with medical chief, polio head, and a polio volunteer each given a page of copy, and recorded that evening on tape.

While the dailies were working overtime in our behalf, the *Dover Advance,* a weekly in whose circulation area lived not only the ostracized P.E.V. but the patient who had been doomed as a carrier, had taken up the story. The *Advance* carried direct quotes from the P.E.V. which gave its story more local feeling.

Finally, a perfect human interest story developed; the mother of a recent polio patient volunteered to take the P.E.V. course—and she lived in the same area where the original turmoil had started. While the family was at the hospital, the father, a Dover dentist, decided to sign up, too, and the resulting feature stories were the best we'd had.

Our polio saga isn't the kind of hospital story that happens often, but it is a heartening example of the happy relationship that can exist between press and hospital.

What makes it exist? Reporters want news. Do hospital publicists give them news, or confine them to handouts, or prepared releases? Do we give them news as it can be used, or do we dish it out guardedly, if at all, afraid of some nebulous concept called "adverse publicity"? Do we give it to them right now, using Mr. Bell's great invention, or are we so surrounded by red tape that six boards have to clear the stuff, at which time it will be dead, not news?

Reporters want the truth. Do we come clean, or do we tell only part of the story? Or do we, worst of all, say we must see a story after the reporter has written it?

Reporters and hospital publicists are working toward the same end. Reporters represent a news gathering agency. Hospitals represent a news supplying agency. The two fit together in hospital publicity as well as in writing news.

2—When Hollywood Goes to the Hospital

the press goes right along

WILL O'NEIL
Santa Monica, Calif.

SOME years ago I took my son over to the kitchen in St. John's Hospital, Santa Monica, Calif., to show him the food service equipment I sell. Object: to increase Pop's prestige with his son.

The trip was a complete flop. For me, that is, but not for the boy. Before I had any chance to lay on with my story he learned that Bing Crosby was a patient and that the kitchen staff was about to prepare a special order tray for Bing. The trip suddenly came alive for the young man. I caught some of his excitement. What would the famous man order?

He ordered an egg salad sandwich.

Bing himself demands little of the hospital at any time during his stay as a patient. But, as a personage, his fame creates certain problems.

On January 18 and 19 of this year newspaper readers across the country got front page news about Bing. He was back in St. John's, this time for surgery. While Bing was deep in the abyss created by the anesthesiologist, St. John's was deep in reporters for the various press media. This reportorial onslaught had begun on Monday evening when Bing was admitted to the hospital.

There are hospitals in which this sort of an invasion, including an almost endless number of telephone calls from the men and women who couldn't stand watch on the spot, would cause a major disruption of the hospital service. St. John's is not one of these. Month in and month out, St. John's houses one or more of the people whose ailments are matters of national public interest. When illness hits Judy Garland, Irene Dunne, Pat O'Brien—to name a few—they become patients at St. John's. By and large, the hospital staff has become somewhat blasé about this continuing flow of famous patients.

The 100 bed main building of St. John's opened in 1942. A new wing, as yet housing patients on only four of its seven floors, eventually will house 165 patients. The need and the drive for capital investment funds has been virtually continuous for 15 years and will continue until the present wing is completed and another is added. So the Sisters (of the Sisters of Charity of Xavier, Kansas) may be more aware than many hospital people of the need for good relations with the press—"press" having long grown to include radio and television, as well as newspapers. The Sisters know what the press wants even if they are a little uncertain at times about why the press wants some of the things it does.

But the Sisters feel, very strongly,

that their first duty is to the individual patient. Had Bing elected, as a not inconsiderable number of the famous do, to register as Chauncey Q. Butterworthy there would have been neither lifted eyebrows nor any disclosure—from the hospital—that the illustrious gentleman was among those present. (Perhaps it should be noted that the press, in its various forms, does not, by any means, agree with this extreme of respect for the patient's privacy when the press considers the patient a public figure.)

Since many of the famous patients are well known in the hospital, it is a rare instance in which the Sisters aren't aware of the patient's true identity. True or false, the patient is asked how he or she wants calls from the press handled, and by whom. Since none of them want to receive calls (in Hollywood you are a tramp if you have to answer your own telephone) most instruct the hospital to refer all calls to the doctor or to an agent or publicity firm.

Bing, when he entered the hospital Monday evening, asked the Sisters to refer all calls, with a list of very few exceptions, to Andy Hervey in the publicity office of Paramount Studios. He even supplied Andy's telephone number. The press in the Los Angeles area is accustomed to getting information about Bing from Andy, so this turning aside of calls by the hospital caused no problem.

All day Tuesday reporters called the hospital wanting to know how and when they could get the earliest possible reports on the results of the surgery —now known about by everyone who could read.

The calls were referred to Mrs. Susan Kelly, the hospital receptionist, who is not only a nice person but is one of those comparatively rare individuals who really likes to greet and care for people coming into the hospital. As soon as the surgery was done the next morning, Mrs. Kelly told the reporters, she would have a bulletin from the surgeon to pass on to them. Mrs. Kelly promised to call people who telephoned her and she made a meticulously careful list of the order in which she was called so she would be sure to follow that order on callbacks.

This proposed program survived only until Mrs. Kelly reached the hospital the next morning, to find her desk already three-deep in reporters. Neither Mrs. Kelly nor the Sisters were aware that editors are convinced nothing can equal on-the-spot coverage in any type of reporting.

The on-the-spot coverage aspect was illustrated by Aline Mosby, representing the United Press and the only female reporter present. What, Miss Mosby wanted to know, is the color scheme in Bing's room? This question was rejected as being neither relevant nor important. This made Miss Mosby unhappy.

Miss Mosby decided that a walk into the (new) north wing, where Mr. Crosby was sure to be housed, would help soothe her feelings. In the wing she came upon a member of the housekeeping staff.

HOW SHE GOT THE NUMBER

"Have Mr. Crosby's relatives come yet?" asked Miss Mosby. The bewildered maid suggested that Miss Mosby go see Mr. Crosby's nurse (he was still up in surgery) and pointed out his room. There went Miss Mosby, color scheme and all. (This will explain to Mrs. Kelly how Miss Mosby got the room number. There were somewhere between five and 50 other ways to get it if that one hadn't worked!)

A private sitting room, off the lobby and close to Mrs. Kelly's desk, was made available to the press, but the reporters preferred, as time went on, to hang over Mrs. Kelly's desk. They even answered her telephone for her when she was obliged to leave for short periods. Most of the calls they and she got were from various other press representatives, some of them calling over and over at 15 minute intervals.

Late in the morning the administrator of St. John's, having surveyed the press situation, went up to surgery to wait for completion of the operation and for Dr. F. C. Schlumberger, Bing's surgeon. The doctor, having seen his patient wheeled off to the recovery room, had moved on into a second patient's surgical problem, unaware that the world was hanging, or waiting to hang, on his every word.

When she had a chance, the Sister administrator told the doctor she much preferred him, as his own reporter, to any written bulletin he or the hospital might issue. It was obvious that it would be better for the surgeon to handle all the press questions at once than to be plagued with telephone calls all day and evening. Dr. Schlumberger wasn't at all sure that a press conference, despite its obvious advantages, would be ethical, but he finally gave in and went down for what turned out to be a very successful session. Mrs. Kelly attended the press conference along with the reporters so she could relay all the information given by the surgeon to the various reporters who couldn't be on the scene.

While Mrs. Kelly is neither a trained reporter nor a press agent, she has demonstrated that the right person, in terms of general background and experience in handling people, fits into a job of this sort very well. Immediately after the press conference everything but Mrs. Kelly's telephone settled down to normal.

Members of the press who were interviewed for this article were critical of certain phases of Operation Crosby. Their suggestions may be of value to other hospitals facing similar situations. Here is the gist of what they said:

Crosby was scheduled to go into surgery at 7:30 a.m. Since the press had learned the type of surgery he was to undergo usually is completed in from one and one-half to two hours they were looking for some report by 9 o'clock or soon after. But no report was given until almost noon.

By that time the wire services, such as Associated Press and United Press, were under considerable pressure from newspapers all over the country. Mr. Crosby was long overdue coming out of surgery and the newspapers were facing recurrent deadlines without any news for millions of anxious fans. So the papers jabbed at the myriad tentacles of the wire services, which jabbed at the Los Angeles tentacles, which jabbed at the subtentacles out in the St. John's lobby, where these reporters kept an incessant nervous pressure on the hospital people.

The fact that Bing hadn't gone to surgery until 8:30—an hour later than originally expected—and that he was out of surgery and in the recovery room about 10:30 would have relieved a good deal of the pressure, if the facts had been conveyed, as they occurred, to the waiting reporters.

On the other hand, reporters commented that the press conference arranged with Bing's surgeon had been an excellent move—an opportunity to get firsthand information which they appreciated. And no man doctoring such a famous personage had much chance of keeping his name out of the papers anyway.

Administration Has to Work Three Ways

A sound relationship must be established among administrator, governing board, and medical staff

MARK BERKE
Director, Mount Zion Hospital, San Francisco

THE relationship between the governing board and the administrator is of particular importance today, because the duties of the hospital trustee are expanding. In future, not only will trustees have to do all the things that we have learned to expect of them, they will also have new responsibilities that are greater than before. The trustee faces swiftly-moving medical progress that is confused by political trends in a situation that involves private health and public health, private funds and public funds, and the ultimate threat of socialized medicine. He is going to be, if he is not already, in the middle of a revolution in all phases of hospital operation from financing to administration; and, of course, it is the problem of the administrator to educate the trustee for this job.

ONE STRONG, THE OTHER WEAK

Too frequently, we find hospitals with a strong administrator and a weak board or, conversely, a weak administrator and a strong board, so that either the administrator dominates the thinking of the board or, in the opposite situation, the director has scarcely anything to say in the management of the institution. Some hospitals, of course, have gone along simply and successfully by permitting all the power to rest in the director and one or two energetic trustees. Now the problems of the voluntary hospital have become so complex because of the many changes that are taking place in our economic structure, in medicine itself, and in the political atmosphere, that the director and all of the trustees will have their hands full; and the medical staff will become more and more involved in the administrative problems of the operation of the hospital.

In discussing the relationship of the administrator to his governing board, we must recognize that to talk about "the relationship" is an oversimplification of the subject, because actually an administrator has many relationships with his board, both on an individual and on a group basis. For example, he will have one relationship with his trustees as a group when he first meets them during the interview for the job; another during his first days or weeks with the hospital; another after he has been there for a year, and so on. In fact, the job relationship with a board as such is constantly changing and growing, varying both with the time and the dynamic state of the hospital.

In addition, there are as many different personal relationships as there are board members, a most potent consideration being social intercourse. There are administrators who deliberately and willingly base their job security on a social relationship with their president or board members. This can be a flattering situation for the administrator, but it carries the seeds of its own destruction because it makes an objective situation dependent on personal reactions; and in an interpersonal exchange, antagonisms may grow swiftly and suddenly out of insignificant acts or words. Presidents change and so do board members, and the supposedly solid foundation of superficial friendship today may prove to be a swamp tomorrow.

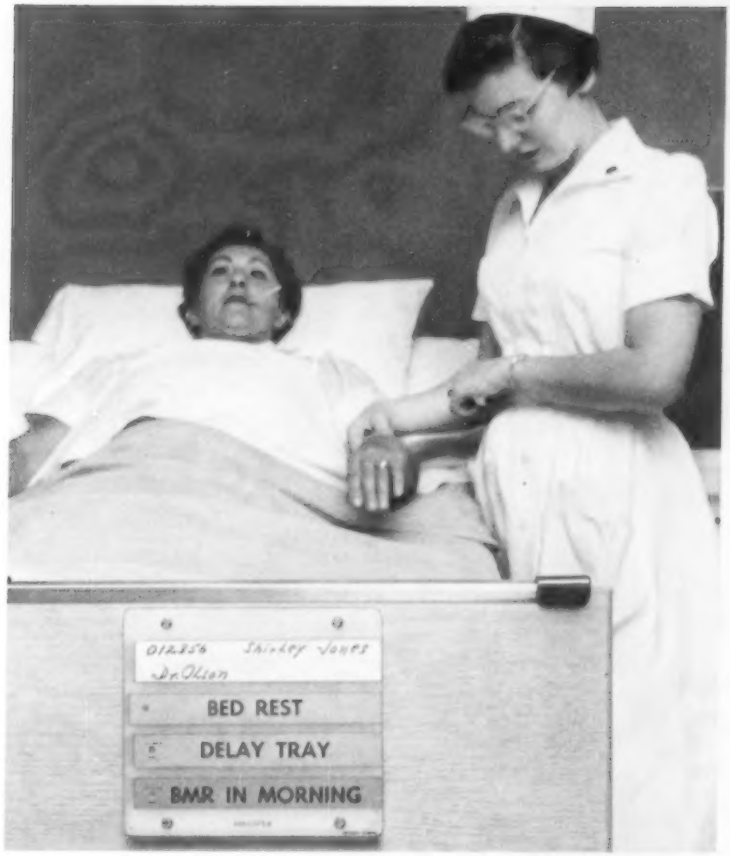
If the relationship between the administrator and his board is to rest on solid ground, we need to spend a little time thinking about how people are motivated, because without some understanding of this it is difficult to work consciously toward developing any sort of relationship with either an individual or a group. As a beginning, it is wise to follow the old saying, "Know thyself," and from this to try and develop some insight into others. What are the drives that make an administrator successful?

NEED FOR RECOGNITION

One of the important drives that motivate most ambitious people—and who but an ambitious person would want to run a hospital with all the headaches involved—is the need for recognition and fame; and it is true that the administrator of a hospital usually has status in the community. If the administrator wants to achieve this status because of his leadership in an excellent progressive hospital, so that he shines by reflected glory rather than by personal aggrandizement, and if this ambition is accompanied by a fair degree of technical competence, then his need for status can, of course, be a real asset to his hospital, his community and himself, because he will devote all his energy toward building up his institution.

Some administrators like the feeling of power, and since he has a great deal of power over employes and doctors, and to a somewhat lesser extent over patients, the administrator, motivated by the power drive, will receive plenty of opportunity to meet his needs. This particular drive is, however, a dangerous one because power is a corrupting influence and can lead to untenable situations. Those with real power drives must attain absolute

Condensed from a paper presented at the Western Institute for Hospital Administrators, August 1954.



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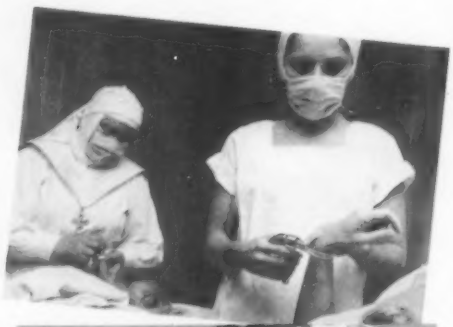

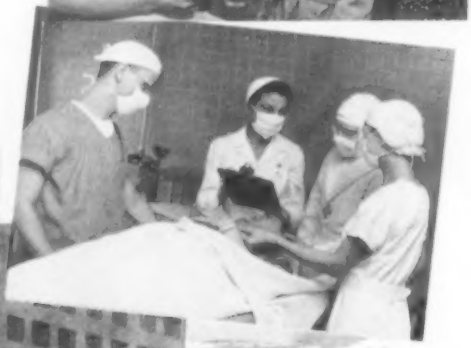

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domination or they are frustrated in their ambitions. Because the administrator is not the ultimate authority, administrators of this type sooner or later find themselves in conflict with their governing boards. And this, I suspect, is one of the reasons there is so great a turnover in the profession.

Many administrators like the feeling of directing things or supervising people. It is interesting to speculate why those with a real talent in this field, who could become successful in industry and make much more money than they will ever earn in a hospital, are attracted to the hospital field. Is it because they are in need of the psychological rest haven that the hospital may be to them? And is that why many people are willing to work in hospitals at lower paid jobs than might otherwise be available to them?

The creative urge is a factor that must also be taken into consideration, and I would think that all successful administrators possess this attribute to a lesser or greater extent. In addition, there would seem to be present an inner benevolence or paternalism which expresses itself in a desire to help and protect others. This, of course, surrounds the administrator not only in his contacts with people in the hospital but in the whole atmosphere that puts the welfare of the patient first in everybody's consciousness.

BRING OUT THE BEST

An undeniably positive attribute that all successful and secure administrators possess is the ability and desire to bring out the best in people, to help them develop to the full level of their potential, and to take part in their growth. If you think about the unsuccessful administrators you have known, you will note that, on an administrative level, the commonest reasons for their failure have been a refusal to help their own people develop and their inability to delegate authority. There seems to be a close correlation between the characteristics that make for a good teacher and those that make for a good administrator.

At any rate, if we think along these lines about our ambitions in hospital administration—and if we get down deep enough, we can learn quite a bit about ourselves in the process—we may be ready to move on to the next step, and to ask why trustees are willing to accept their unpaid, time consuming and difficult tasks on hospital boards.

Some trustees—and they are the outstanding ones—are genuinely interested in the welfare of the community and in improving it. These are the board members who are good to work with, because even when their approach is faulty and their conclusions incorrect, their motivations are healthy and sound and the administrator knows that, no matter what conflicts arise, the goal is a common one and problems can usually be ironed out.

Some trustees may be motivated by such drives as the desire for power and the ability to scatter largesse in the form of personal favors, or the wish for status, or by the possession of a great social conscience. There are other drives which may be applicable, but it is important to try to find out what they are so that our understanding of the individual may be used to develop this relationship between administrator and trustees.

These are the preliminary steps to the development of good relationships. The question of how one uses this knowledge is something else again, and whether one can actually develop a rationale on this subject is a little beyond me. The board, in its deliberations, is following a process of group thinking and, in its best manifestation, the administrator is the leader of the group. If a group ideal can be set up and shared on a group basis, if a group conscience can be created with the administrator an integral part, then the soundest relationship possible automatically exists. Obviously, it takes a long time to develop this state of rapport, and just as obviously it takes a skillful administrator to aid in bringing it about, and I doubt whether this skill can be consciously learned. It is, I think, an unconscious skill. The really successful administrator possesses it entirely; the poor administrator not at all, and the average administrator possesses it in part.

A truly sound basis for a good relationship is, as we have said, mutual trust and understanding; and this is, in itself, dependent to a large degree on the honesty of the administrator. The director of a hospital is in a most delicate position, being caught between two forces—the governing board on one hand, and the medical staff and personnel on the other. Each force has varying degrees of socio-economic and psychological dependence on the hospital and the administrator must remain objective and unbiased, facing all issues frankly and honestly. This is a difficult thing to do, and it is really much easier to play politics and align oneself with a particular faction or power. That way, the administrator can easily persuade himself that the side he is on is the good side—the side that wants to do the right thing—the side that has only the good of the hospital and its patients at heart. The other side, of course, is selfish and seeks only to serve its own ends. Thus, the issues are simple and quite easily handled emotionally by the administrator, especially since he normally allies himself with the group that he believes to be the strongest.

INTRIGUE DOESN'T PAY

That way lies intrigue and scheming and danger, however. There was an administrator who had been in one hospital for more than 15 years, happy and comfortable in a rather static situation. Then came the war years with their shortage of beds and difficulties with physicians, and unfortunately the advent of a new board president who was really a troublesome man, although dynamic and knowledgeable. The administrator became more and more unhappy and the president more and more disliked even by his own fellow board members, and at the end of the president's term the administrator saw his opportunity and actively campaigned against his president's reelection. He almost worked it, too, but not quite. The president was reelected and within 30 days of that tragic occurrence the administrator was fired — fired after almost 20 years with one institution.

Another administrator was quite free in his criticism of his president and in organizing cliques and factions within the board to work against the president. He was successful in this and, indeed, in eventually getting the president replaced by a board member who had been friendly with the director both on a board level and on a social basis. Within six months, however, the administrator was looking for another job because, as the new president told me, a president should have an administrator whose integrity can be trusted.

Every administrator has had or heard of similar experiences which demon-

strate that the use of politics or the reliance on social relationships or the development of similar substitutes for an honest and straightforward administration can lead to only temporary advantage; and I think we can agree that good relationships cannot be permanently maintained on such a basis.

THERE WILL BE DISAGREEMENTS

It is important to realize that good relationships do not mean that there will never be any disagreement or conflict between a board and its administrator. An organization in which there are no constructive arguments would be a dull one, and one in which nothing is being done; and while the board has delegated executive duties to him, the administrator must accept the fact that the board reserves the right, and must reserve the right, to change or modify his decisions, and to accept or reject his policy recommendations. Under ordinary circumstances, the administrator should not feel that occasional adverse action on policy matters reflects a lack of confidence in his administrative abilities, although he might be justified in so feeling if the board frequently refuses to accept his advice. Because he was engaged as an expert, his advice should be obtained when changes of any kind are contemplated, and if he finds that changes are often thought of without his instigating them, or without his advice being accepted, he has a right to consider that a lack of confidence is being shown in him.

On the other hand, when an administrator is forced to change an administrative decision by his board, the situation is different, and it should not take many incidents of this type to make the administrator decide that the time has come to improve his relationships with his board or, if this is too difficult, to move on.

Because board interference of this type, destructive even though legal, is not uncommon, one wonders why more administrators do not reach an understanding with their boards at the very beginning. A board must recognize that its administrator is human and will make his fair share of mistakes; and it must be prepared to give its executive a reasonable and just amount of support in the carrying out of his assigned duties, and to submit cheerfully to an educational process since, presumably, the administrator knows more about hospital administration than does any individual member of his governing body. Some trustees will not agree with that statement, of course, and habitually interfere directly or indirectly with the operation of the hospital. This represents another problem in human relationships for the administrator, and whether it is best to work with the negative type of trustee directly or whether it is best to work through the president or some other influential trustee is something that can only be decided by the circumstances.

The question of education is important. We have said that the board should be prepared to learn from its administrator. The administrator, of course, has a great deal to learn from his board members because, if they have been chosen as they should be with an eye to diversification of interests so that the hospital has many talents and disciplines available, each member has something to contribute to the administrator. The good administrator is always eager to learn, and he knows that everybody has something to teach him—everybody, from the porter to the trustee. Everybody likes to be appealed to on the basis of experience and wisdom, and the wise administrator never hesitates to ask a board member for aid in the field for which the trustee is especially equipped.

One of the chronic difficulties in maintaining good relationships with the board is: How does an administrator keep his board consistently informed of developments in the hospital? This opens up the whole field of communications in which so much study is being done today.

Communication with the board of trustees is perhaps somewhat simpler than it is with other members of the hospital population because while the number of trustees on the board may vary from hospital to hospital, ranging perhaps from as few as five to as many as 50, we still have one solid group to deal with. But we must not underestimate the importance of communications because of this, since we will find that if we do not inform the board members, and keep them informed, they will get their information from other sources which are perhaps not quite as accurate or as objective as the administrator's would be.

The best method of keeping the board informed and of having a record of what material has been supplied to the board is in the form of written memorandums, which, of course, should be objective and present both sides of a problem. However, most board members do not have the necessary time or the patience to study lengthy documents, and in any case much of the written material presented to board members must be discussed orally and at some length with various interested trustees. In addition, the administrator should be present in person at board meetings and committee meetings. This seems obvious enough but, strangely, there still exist in various parts of the country hospitals in which the administrator does not attend board meetings. One naturally wonders how well such a hospital can be run.

COMMITTEE MEETINGS VALUABLE

The opportunity of the administrator to sit in at committee meetings is perhaps more important in transmitting information to board members than is his presence at the board meeting itself. At the latter the administrator may very well play a rather quiescent rôle, as his own recommendations with regard to the subjects under discussion will already have been made to the president or to the various committee chairmen, and he will frequently simply sit by unless a point of information is desired. During committee meetings, however, he has an opportunity to stress his own point of view and to win the committee chairman over when necessary.

Further opportunities arise in the transmitting of information to the board through individual meetings with such members of the board as have time. This presents the administrator with an opportunity also to familiarize the board member with the physical hospital.

Financial reports and statistical reports all serve to keep the board informed, but they should be kept short and concise and, above all, they should convey the information that the board wants to have, not simply what the administrator wants his board to know.

In addition to all this, the administrator must find ways of keeping his trustees informed of not only major projects and progress—but of keeping them informed of the small day-to-day happenings and changes that are really the pulse of the hospital. Usually the trustee picks these things up second hand, and he wonders why

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he was not told officially, although it is manifestly impossible for the administrator to detail all small items to his entire board. Each administrator must find his own way to solve this problem, of course, but it should be solved.

You might be interested in knowing how we've handled it at Mount Zion. Knowing that most board members are interested in medical matters, we have for almost two years published a monthly Mount Zion *Bulletin*, edited by and for the medical staff. This publication contains items of interest to our physicians, and a regular letter from the administration with all sorts of administrative information, such as changes in admitting rules, description of new services, and changes in department heads. In addition, almost every month there is a one-page survey of the functions and responsibilities of an administrative department, the most recent being the personnel department. Copies are mailed to all physicians and members of the board, as well as interested people in the community. Our trustees are quite pleased with this method of communication, and several have told me that they have never been so close to or familiar with the intimate details of the hospital.

In this connection, we must bear in mind that while the topic under immediate discussion is the relationship between the administrator and the governing board, we cannot omit some reference to the relationship between the administrator and the medical staff since these three components—the administrator, the governing board, and the medical staff—are really in a three-way partnership in the hospital. Rarely do we find a situation in which at least some members of the medical staff are not also personal friends of, as well as professional consultants to, a member or members of the governing board. The relationship between the administrator and the governing board is bound to be affected to some degree, anyway, by that administrator's relationship with those members of the medical staff who are also personally connected with members of the governing board. In addition, comments made by physicians to people in the hospital and in the community have an unfortunate habit of reaching the ears of board members, especially when the comments are unfavorable.

As we know, doctors are individualists. They become so as part of their training, and in the final analysis they feel that the hospital is really an extension and elongation of their own needs. Most of them are concerned only with the care given to their individual patients. This is perhaps as it should be, because through the doctor's demands for his patient, the patient gets the best of care. However, I think we must also recognize by the same token that most doctors do not believe in organization in a hospital. Perhaps this is not a conscious rejection, but it is certainly an unconscious one and I am sure that the average doctor, without admitting it and perhaps without even knowing it, would prefer to see anarchy in a hospital rather than an organized administration. In anarchy, everybody can do as he pleases, and the doctor can always get what he wants, whereas in an organized situation there are rules and regulations that must be followed and which bind both him and his patients.

To avoid misunderstanding, it should be made clear that these comments are not intended to be critical of the medical profession. They are justified in caring only for their patient's welfare, and their unconscious reaction to organization in a hospital is completely understandable within the framework of their personal relationship with patients.

In other words, since the doctor is not particularly in favor of organization, we must be especially careful not to make him feel that we want to be dictators. In effect, this means adopting a position of arbitration, and not always one of immediate god-like decisiveness. It is simple on receiving a request from a physician to say: "No, this is not practical" or "We don't have the money to do this." That is an attitude which is quite often adopted by administrators and one that is most likely to lead to trouble. It is not quite so simple to say: "Well, let's discuss this. I'm not sure whether we can do all you want, but let's see how much we *can* do." It is not as simple to do this because it means discussions, problems, work and, of course, an investment of time, and yet it seems to me that that is the only practical method to follow if the relationship between the administrator and his medical staff and therefore between the administrator and his governing board is to be sound and healthy.

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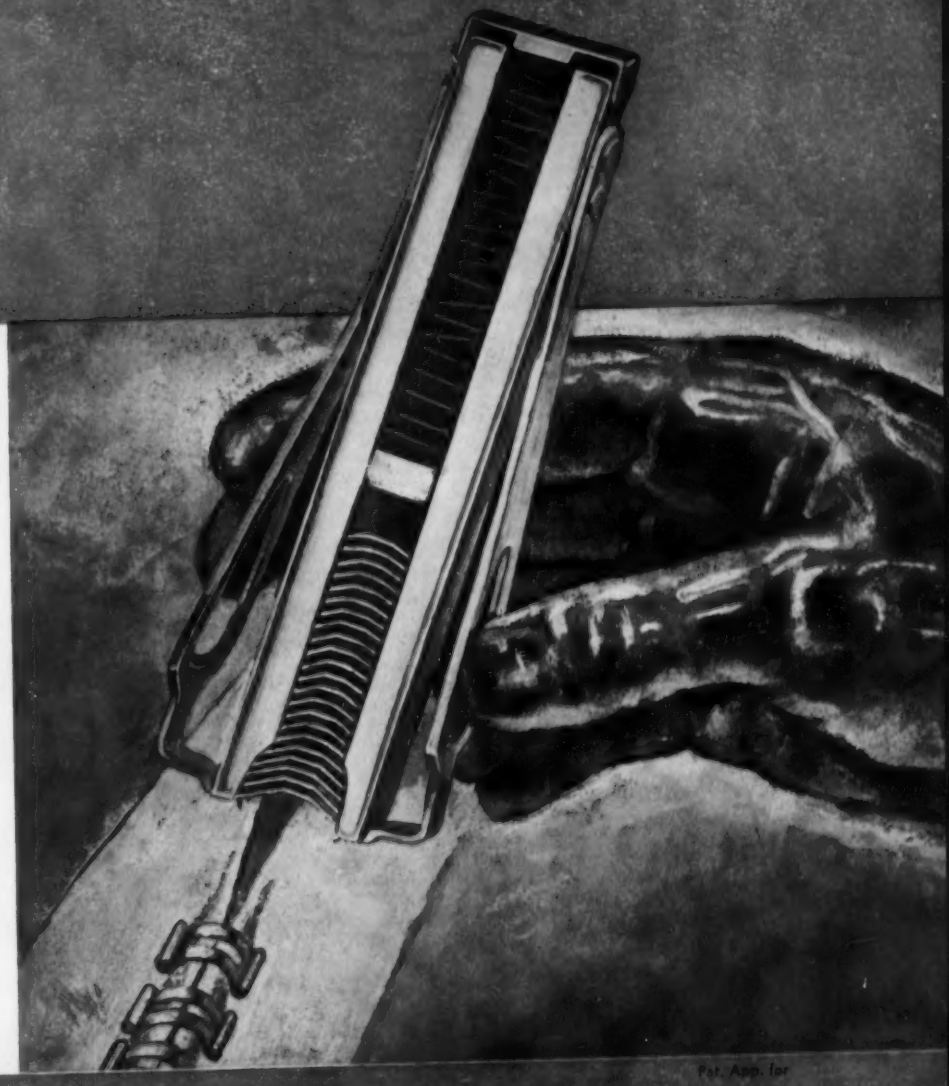

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Make the Most of the Medical Audit

LUCIUS W. JOHNSON, M.D.
San Diego, Calif.

IN THE March issue of The MODERN HOSPITAL, Dr. Johnson defined the medical audit, explained the two principal types of audit, and answered questions about their advantages and disadvantages to hospitals and medical staff members. In the second, and concluding, section of his article, he discusses how and by whom the audit should be made and how the hospital and staff can make proper use of the results of the audit to improve standards of patient care.—ED.

1. How is the continuous self-audit done?

Several hospitals have developed their individual methods. A pamphlet prepared by the staff of Grant Hospital, Chicago, states that the audit is done by the medical records committee, which meets weekly to review all records of discharged patients. It studies the relation of clinical and laboratory records to the diagnosis; the suitability and efficiency of the treatment; complications and their causes; deaths, autopsies and consultations; adequacy of the record; justification for surgery; suitability of the operation, and its success. Each physician has an index card, kept in a confidential file, on which are recorded the results of the audit that relate to his work. When any action is required, recommendation for it is made to the executive committee of the medical staff.

In the Woman's Hospital, New York City, the audit has been an annual feature since 1918. It is prepared from the hospital records by a statistician. Standard forms for history and physical examination are used and they are completed in a standard way. Discharge notes contain data that show clearly the patient's condition and the results of treatment. The audit is stated to reveal the quality of work done by each member of the medical staff. It provides the basis for granting, withholding or modifying privileges in each department.

From several other hospitals have come articles giving in detail their methods of conducting the audit. In general, they conform rather closely to the plans that have been described.

2. How is the audit by an independent outsider conducted?

The usual procedure is for him to:

Examine all clinical records of patients discharged during a six months or 12 months period.

Review the educational background, experience and qualifications of each physician on the medical staff.

Examine records of meetings of the governing board, medical staff, joint conference committee, records and tissue committees, clinico-pathological conferences, and others.

Study the charter, constitution, by-laws, rules and regulations.

Examine necropsy and accident reports, consult Blue Cross and other insurance carriers.

Study all statistical data on professional work of the hospital.

Consult with the hospital attorney, newspaper editors, and many citizens, to estimate the public relations of the hospital.

Look for evidence of incompetent administration, lack of essential services and incompetent workers, poor supervision of patient care, and faulty personnel practices that lower morale of workers.

3. What data will the independent auditor require?

He is likely to request these:

For the hospital:

Average bed capacity, occupancy, length of patient stay.

Death rate: total, infant, maternal, postoperative.

Necropsy rate, consultation rate, cesarean section rate.

Hospital charter, by-laws, rules and regulations.

Minutes of meetings of governing board.

Minutes, attendance records of medical staff meetings.

Minutes of joint conference or advisory board meetings.

Minutes of clinico-pathological conferences.

Minutes and reports of tissue and records committees.

Death and autopsy reports.

Reports of anesthetic and other accidents.

Clinical records of patients discharged during the period.

Newspaper clippings about the hospital, its staff and work.

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internships and residencies — when, where, how long, department; certifications, society memberships, postgraduate courses—when, where, how long, subject.

Number of patients: total, medical, surgical, obstetrical.

Death rate: total, medical, surgical, infant, maternal.

Number and type of emergency operations (out of regular hours).

Consultation rate: those he requested, those he was requested to do.

Percentage of necropsies on his patients who died.

Percentage of attendance at staff meetings.

Percentage of normal tissues removed, with case numbers.

Percentage of cesarean sections on his maternity patients.

Number of abortions and types; of D & C's; of sterilizations.

4. What inferences can be drawn from each of these?

Bed capacity may indicate how completely the hospital is filling the need of the community.

Occupancy may suggest overcrowding or unwise use of beds.

Length of patient stay may suggest abuse of Blue Cross or other third-party arrangements.

Death rate is not a reliable index of quality of service, but it often points to details that need investigation.

Necropsy rate is a guide to the interest in scientific medicine and desire for progressive improvement by the medical staff.

Consultation rate is a check on the competence of physicians, and relations within the staff. Who calls for Dr. X? Whom does he call on for consultation? These can give valuable leads.

Do the hospital's charter and by-laws provide a firm basis for restrictive action? Do they support good ethics, good records, good management, good morale?

Minutes of governing board show whether members are aware of their obligations to the patients; whether they act firmly and promptly to control detrimental trends; what problems have arisen and how they were handled. Is the administrator allowed to have authority he needs in order to do the work for which he is trained?

Minutes of staff meetings show whether or not the type of staff organization is suitable; whether or not it provides a good framework for self-government. Are ample facilities provided for general practitioners? Do aggressive competition and uncontrolled ambition cause friction? Is time wasted in bickering over details that the executive committee should decide? Are the doctors willing to give time for discussion of deaths, failures and improved procedures?

Minutes of committees show how well they are performing their functions, where there is poor performance, and what is done to control it; also the attitudes of committee members are clearly shown. Can operations be done without prior study? Can deaths go unexplained? How thoroughly are the ability, education, ethical character and identity[1] of applicants for medical staff privileges investigated?

Death, necropsy and accident reports give many valuable sidelights on the quality of the service and the attitudes of doctors.

Each one of these details gives also important information on the ability of the administrator to harmonize all the activities of the institution.

The data on applications for staff membership help to compare the individual's background of training with the quality of his work. Does he attempt major procedures for which he is not well trained? How does his work after a refresher course compare with that in his past? Does he use new methods intelligently? If certified, is his work on the extra high plane that his training should justify?

The death rate may give important information on the quality of his work and his attention to his patients.

The number and type of his operations outside regular operating hours may indicate his cooperation with the hospital group. Such operations are costly to the patient and the hospital. They disrupt the routine by interfering with the orderly flow of supplies and services. They have been used to camouflage ghost surgery, also illegal and unnecessary operations.

His consultation rate may show the doctor's estimate of his own ability, his standing among his colleagues, and his interest in the welfare of his patients. Does he call mediocre men, or the best available? Does he call in outsiders (this has been used to cover up ghost surgery) when men of equal ability are in his own hospital group? These points throw light on the degree of harmony among the members of the medical staff.

The percentage of normal tissue surgically removed may be a bone of contention. Some surgeons have claimed that the American College of Surgeons has issued an edict granting 15 per cent of normal tissue before a surgeon's work can be questioned. The only safe way is to judge each case on its individual merits. The pathologist and the tissue committee serve the interests of the patients in this field.

5. How is the report of the auditor made?

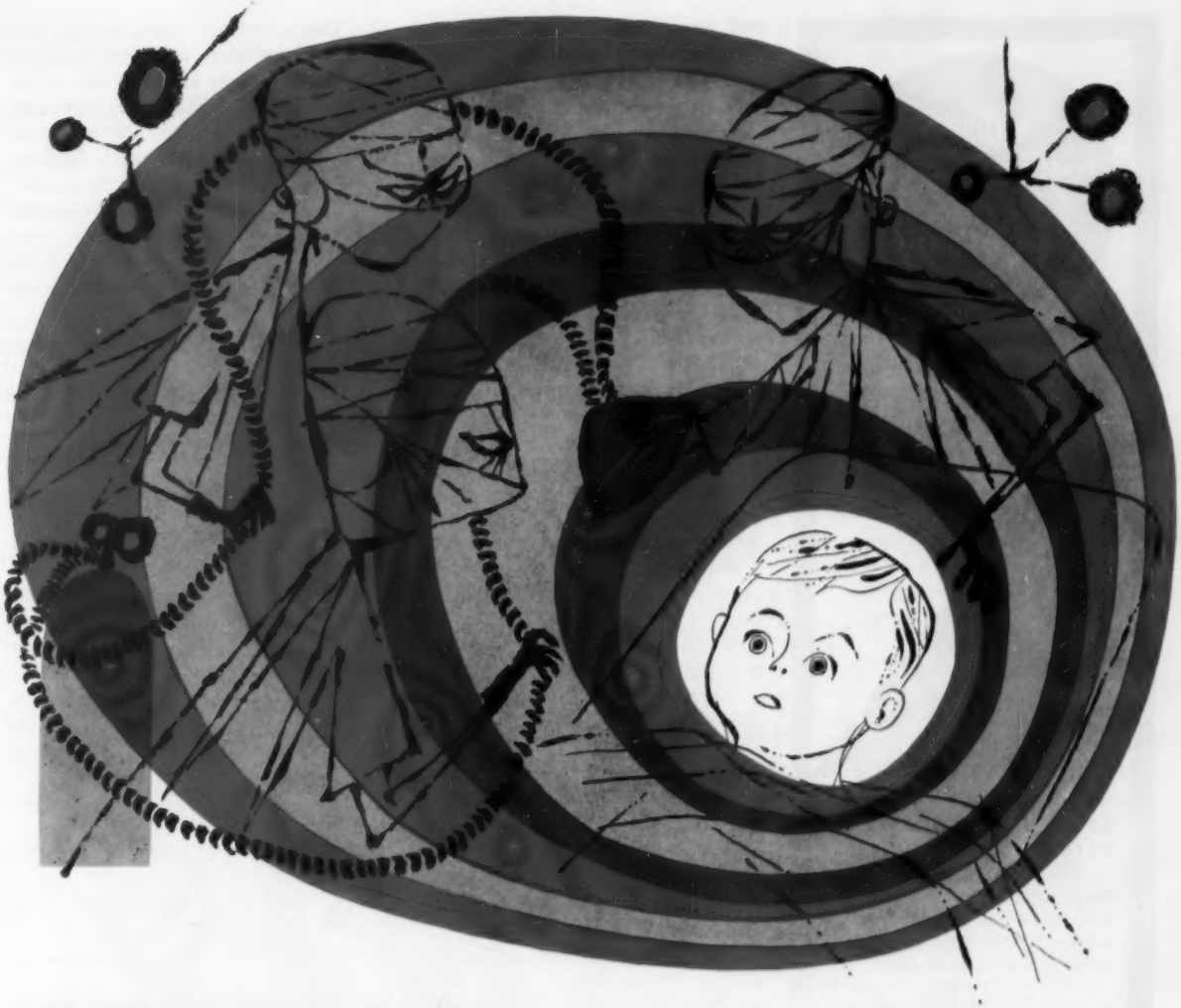
It may vary according to the wishes of the hospital group that contracts for the audit. There usually is a report on the professional service with recommendations for its improvement; also a report on the administration, the governing board, and the public relations. This report may be read and discussed in meetings with the medical staff and with the governing board, or in a combined meeting. The auditor should be prepared for uninhibited heckling. Usually these are closed meetings, but sometimes the group invites the press. The whole report, or parts of it, may be given to the press, as the local group decides.

There is also an individual report for each member of the medical staff. It contains an estimate of his qualifications and the success of his professional work, with recommendations for privileges to be granted him in each department of the hospital. Each of these individual reports is marked with a symbol, so that it can be discussed in staff meetings without revealing the name of the individual. These reports are usually handed to the chief of staff, together with a sealed envelope containing the key to the symbols.

This report provides a basis for recommendations by the staff to the governing board for privileges to be granted to individual members of the medical staff. It shows which ones should have their privileges limited, their work supervised by departmental committees or controlled by requiring consultations.

Another way of making the report is to submit to the staff and the governing board a list of case numbers, with comments on the way they were handled, and the results. When these cases are studied, the discrepancies noted and evaluated by competent

[1] See Williams, Greer: The Doctor Was a Fake. Sat. Eve. Post, Nov. 13, 1954.



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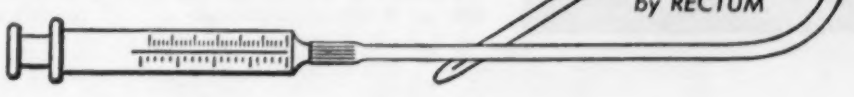

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staff committees, the way to effective action is clearly indicated.

6. How does the audit help in improving professional service?

It is widely recognized that the vast majority of physicians are earnestly trying to maintain and raise the standard of hospital service but, since doctors are human, some of them need to be restrained. The audit helps by:

Pointing out those whose ability, attitudes or practices are detrimental to the welfare of their patients, to harmony within the group, or to the reputation and public relations of the hospital.

Suggesting how their work may be controlled by limiting their privileges, requiring consultation, or requiring supervision of their work by competent staff committees.[2]

Indicating what staff committees are needed and how they should function.

Recommending changes in staff organization.

Pointing out to administrators and governing boards how they may aid staff improvement.

Emphasizing the value of continuous educational progress through better programs of staff meetings, improved clinical records, and clinicopathological conferences.

7. After the audit is completed, how should the group proceed?

The medical staff, administrator and governing board should devote meetings to study of the report. Each one should list the recommendations that apply to its field.

The administrator and governing board should assure the staff of their firm support of staff action to improve the professional service.

The staff should choose doctors of the highest professional qualifications and ethical character as members of the executive, departmental, tissue, records and other committees. It should recommend to the governing board privileges for individual members in each department of the hospital. These should conform with the recommendations of the audit report, or else state the reasons for the variances.

The administrator should forward the recommendations to the governing board, with comments on the variances.

The governing board should give careful consideration to the privileges recommended by the staff, also to the comments by the administrator. Its decisions should be on the basis that the welfare of the patients is the paramount consideration.

The administrator should keep fully informed about the progress in carrying out the recommendations of the audit, and keep the governing board informed.

8. How is the value of the individual staff member estimated?

The following data illuminate this point:

His background of education, training and experience.

The number of his patients and the success of his clinical work.

His compliance with the by-laws, rules and regulations.

The quality of his work for the staff organization, attendance at staff meetings, presenting cases, work on committees, giving time for education of nurses, interns, residents and others.

Study of the cases in which he calls for consultation, or is asked in consultation.

His unsuccessful cases, and his percentage of necropsies.

Comments on his work by records and tissue committees.

Harmonious relations with other workers on all levels.

9. Do certified specialists receive special attention?

Indeed they do. Their records are carefully studied to see if the quality and the results of their work measure up to the extra high plane on which their special training should place it. Merely average work by a certified specialist is considered cause for severe criticism.

Many people forget that certification and membership in specialist colleges mean mostly that the individual has completed certain formal training. It gives no assurance of high ethical or moral standards, of devotion to the welfare of his patients, of compliance with hospital by-laws, or of friendly cooperation with his colleagues. In fact, some of the most highly trained specialists are not team workers at all, but aggressive individualists, and a thorn in the side of their hospital groups.

10. How can the audit aid the public relations of the hospital?

The auditor is prepared to address service clubs, chambers of commerce, parent-teacher associations, and other

[2] 82 per cent of general hospitals in the United States limit surgical privileges and 93.4 per cent of hospitals over 100 beds define and restrict surgical privileges.

groups that have an important influence on public opinion. Speaking as a disinterested outsider, he has an excellent opportunity to present modern hospital standards, the function of the hospital in the community, the laudable desire of the local group to work together for better service to patients.

Similar talks are often held with newspaper editors and local radio or television stations. Emphasis on the good features of the local hospital, and the benevolent desire of the governing board and medical staff to subject themselves to criticism in the effort to improve the quality of professional care have proved most helpful.

11. How can the audit aid Blue Cross and other insurance carriers?

By contrasting the length of stay of uninsured, Blue Cross insured, and those insured by others. This can be done for the whole hospital, also for each individual staff member.

Some startling facts can be disclosed by observation of the x-ray and laboratory tests, medication, operations and other procedures requested for the three groups of patients, their results, and their relation to the final diagnosis.

12. Is the auditor interested in other than the surgical and obstetrical departments?

Yes. Poor control of the quality of professional work can be just as damaging in other departments. Here are some of the deficiencies commonly observed:

Abuse of narcotics, antibiotics and other costly or dangerous drugs.

Failure to call for consultation when needed. The American Academy of General Practice is said to have published a list of 11 ailments in the medical field, for which consultation should always be required.

Failure to take adequate history or make physical examination.

Length of stay unrelated to diagnosis or seriousness of condition.

Cross infections and complications too frequent.

Errors in diagnosis and therapy too frequent.

Failure to obtain necropsy in unusual or doubtful cases.

Failure to try or to evaluate new methods of therapy.

Lack of appropriate x-ray, laboratory or other diagnostic tests.

Inadequate nursing or other services.

Neglect of patients by attending physicians.

Agreement by American Medical Association and American Hospital Association on doctor-hospital relations not observed or not working well.

Cases with unsatisfactory outcome not discussed in staff meetings.

Clinical work not actively supervised by departmental committees.

Doctor and hospital not protected against damage suits by suitable clinical and other records.

Privileges of individual staff members not justified by the quality of their work.

13. How can the hospital group best fulfill its obligations?

By adopting the standard charter, by-laws, rules and regulations, then enforcing them firmly and impartially.

By careful selection of members of the medical staff, and careful control of their privileges, advancement and tenure.

By clearly defining privileges in each department.

By controlling the quality of the professional work, with the aid of the

tissue committee, records committee, clinico-pathological conferences, consultations and the medical audit.

By appointing a vigilant chief of staff with a strong sense of responsibility and the courage to act when needed.

By providing competent, conscientious and steadfast heads of the diagnostic services, also firmly supporting their recommendations.

By providing a firm, alert, tactful, well trained administrator and giving him the authority and support that he needs.

By thorough indoctrination of members of the governing board. They should be carefully taught their duties, obligations and limitations.

14. Has there been favorable comment on the audit?

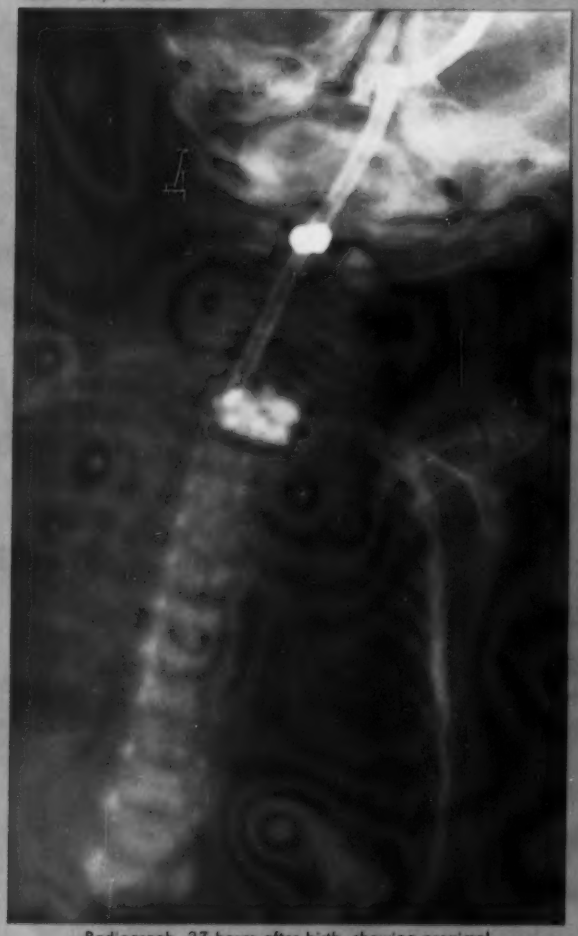
Yes, the value of the audit has been aptly expressed by Dr. John R. Orndorff of Chicago as follows: "If the medical audit were adopted on a national scale and sufficient publicity given to it, the public would learn that medical care was being investigated and its quality improved. The nation would be less likely to believe that there could be greater efficiency and protection under a government controlled program. The strengthening of our position that would result from a national medical audit is, [sic] I believe, tremendous. Each community would know the directors of their local hospital were keeping a continuously watchful eye on the quality of medical care. . . . Introduction of the national medical audit might prove in the end to have been one of our greatest assets in the successful struggle to educate some of the people away from a desire for socialized medicine."

15. Has the audit been unfavorably criticized?

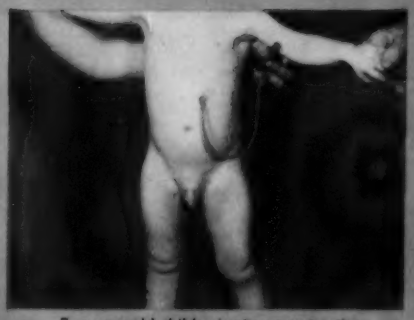
Yes. Some have contended that because our knowledge of the human body, disease changes, and drug action is so imperfect exact analysis of medical care is not possible. It is an injustice to examine with a mathematical slide rule like the medical audit such a highly individual activity as medical practice.

The critic's hindsight makes him feel superior and so his judgments are too drastic. There is always the possibility that the whole thing will turn into a witch hunt. It is said to be impossible to prevent personal prejudice from playing a major part in the auditor's decisions.

Late reconstruction of congenital esophageal atresia by intrathoracic colon transplantation.



Radiograph, 27 hours after birth, showing proximal esophageal pouch.



Two-year-old child prior to reconstruction.

Right colon mobilized.

Right colon lying on chest wall.

(For additional illustrations of this case, turn page)

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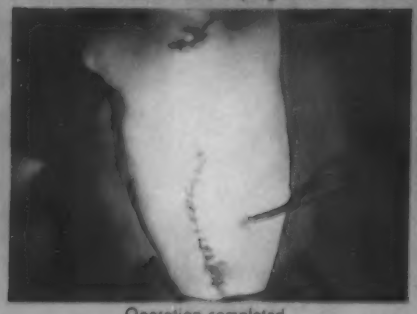
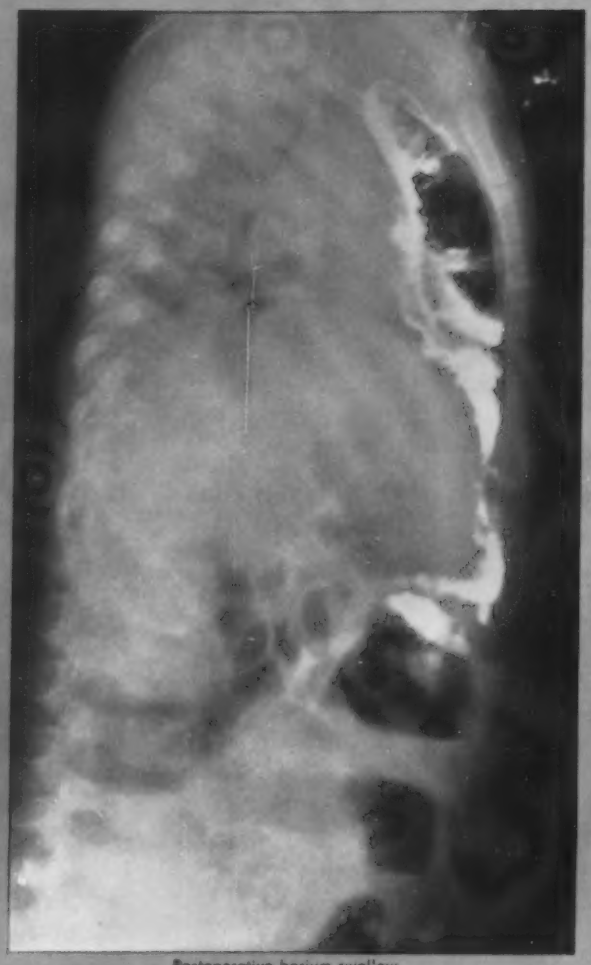
Colon pulled through sub-sternal tunnel.

Anastomoses in progress.



Operation completed.



Postoperative barium swallow.

Radiographs and photographs courtesy of The University of Rochester, School of Medicine, Rochester, N.Y.

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(156:991, Nov. 6, 1954):

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A new angle on early ambulation:

Central Dining Service for Surgical Patients

DANIEL J. LEITHAUSER, M.D.
St. Joseph's Mercy Hospital, Detroit

PATIENTS hospitalized for any type of illness today are receiving care and treatment that is radically different from that to which they were subjected 15 or 20 years ago. The dramatic changes in therapeutic methods have developed so rapidly and so recently that they have not as yet had any significant influence on the architecture or functional design of floor space in hospitals. The structure of our present buildings reflects ideas of therapy that were developed during the Nineteenth Century. It is high time that the advances of the Twentieth Century be taken into account in remodeling present facilities and in the planning and building of hospitals for the future.

Until the hospital environment and facilities are modified to meet modern requirements, the full benefits to be derived from progressive methods will not be achieved. Physicians and surgeons in all departments, I believe, should offer suggestions to hospital building committees and planning boards as to modifications and improvements that would be desirable in augmenting the use of modern technics and procedures of diagnosis and treatment.

In my own clinical investigations on the development of methods of postoperative care for ambulatory patients, I have often encountered certain limitations and frustrations imposed by the physical setup in the hospital, which was designed and organized for very different practices. On the basis of this experience, I should like to present a few concrete ideas for necessary and desirable features that should be incorporated into the remodeling and construction of hospital buildings. It would be well to mention briefly the contrast between the present and the past in the management of surgical patients to demonstrate that certain modifications in hospital construction and floor design should logically follow the clinical changes that have already occurred.

The trend is increasingly toward ambulation immediately after operation, with insistence on frequent walking and other activity as a means of promoting restoration of normal circulation and respiration. Surgical procedures which formerly resulted in prostration and incapacity, with the patients required to stay in bed for two weeks or more, now are so managed that the patients are ambulatory throughout convalescence. In many instances, they are fully recovered and able to return to work within a week or two. The average stay in the hospital after operations has been reduced by more than one-half and there has been a marked reduction in postoperative complications and mortality, despite the fact that the number of surgical procedures of major magnitude has increased.

To implement a therapeutic program in which the patients are to receive the maximal benefits of walking and other physiologic activity immediately after operation, numerous changes in the traditional hospital setup and routine are desirable. The first need is that adequate space for a large recovery room be available on the operating room floor. Some hospitals already have recovery rooms, but their function usually is limited merely to keeping the patients until they are safely out of anesthesia, for the purpose of relieving the nurses in the wards from the responsibility of the close observation required.

In my opinion, the function of the recovery room should be expanded. All patients should be transferred to the recovery room immediately after surgery, where they can be observed and cared for by a specially trained nursing staff skilled in handling all types of emergencies and in administering and supervising all the procedures necessary during and immediately after recovery from anesthesia. This should include the supervision and assistance necessary in the patients' first ambulatory periods. It should be the respon-

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sibility of the nursing staff in the recovery room to assist the patients to walk short distances, as frequently as every hour for several hours, beginning as soon as the effect of the anesthetic has disappeared. Usually by the third or fourth hour, patients require no further assistance in getting out of bed and should then be given instruction as to the necessity for continued frequent ambulation, on their own responsibility, after their transfer to the ward.

With this concept of a recovery room, it would indeed be what its name implies—that is, the patients would remain there during the period that they require closely supervised nursing care, transfusions, intravenous and parenteral medication or feeding, and assistance in ambulation. As soon as they are able to get out of bed and to walk without help, surgical patients (if they do not receive too much narcotic medication) as a rule are ready to move to the ward or private room, where the process of convalescence is continued and speeded by constantly increasing activity.

On the wards, the majority of patients are ambulatory at will and almost completely independent, with bathroom privileges and the ability to take care of other routine physical needs. Others may require some aid and encouragement, for a short time, from an attendant or nurse. The bedpan has lost its status as the disagreeable symbol of the discomforts of postsurgical hospitalization, nor is it any longer the bane of the nurse's professional duties.

Modern therapeutic methods have not only greatly shortened the period of hospitalization, but they have also changed the entire atmosphere of the hospital for the patient. Instead of having to endure a depressing nightmare of isolation, suffering and impotence, as a completely helpless invalid dependent on narcotics, the patient has a sense of participation in his own recovery, in the company of others who are having a common experience. The negative psychologic attitude of fear and frustration, which was almost always present in the past, has been changed to a positive feeling of hope and of determination to work toward a renewal of physical power. When he is encouraged and urged by his surgeon and by the nursing staff to do so, the patient takes great pride in the contribution he himself makes toward recuperation, through his own activity.

The emotional attitude changes in such a situation, so that the patient no longer boasts of how desperately ill he was, how long he was incapacitated by his illness, and what a good doctor he must have had to rescue him from "death's door." Instead, he gets his satisfaction and makes his bid for attention on the basis of his superior accomplishment in achieving recovery at the earliest possible moment. He becomes proud of what he *can* do, instead of what he cannot do. A healthy spirit of friendly rivalry and competition with others develops in this "game of getting well."

Several years ago, the idea occurred to us that a logical extension of ambulatory activity and bathroom privileges would be a cafeteria type of dining room where the patients might choose their own food, serve themselves and enjoy the companionship of others during their meals. It was thought that this would contribute greatly to the psychologic attitude of recovery. Sister Mary Presentation, superintendent of St. Joseph's Mercy Hospital, Detroit, agreed to an experiment along this line, and installed a dining room

for ambulatory surgical patients on one of the surgical floors.

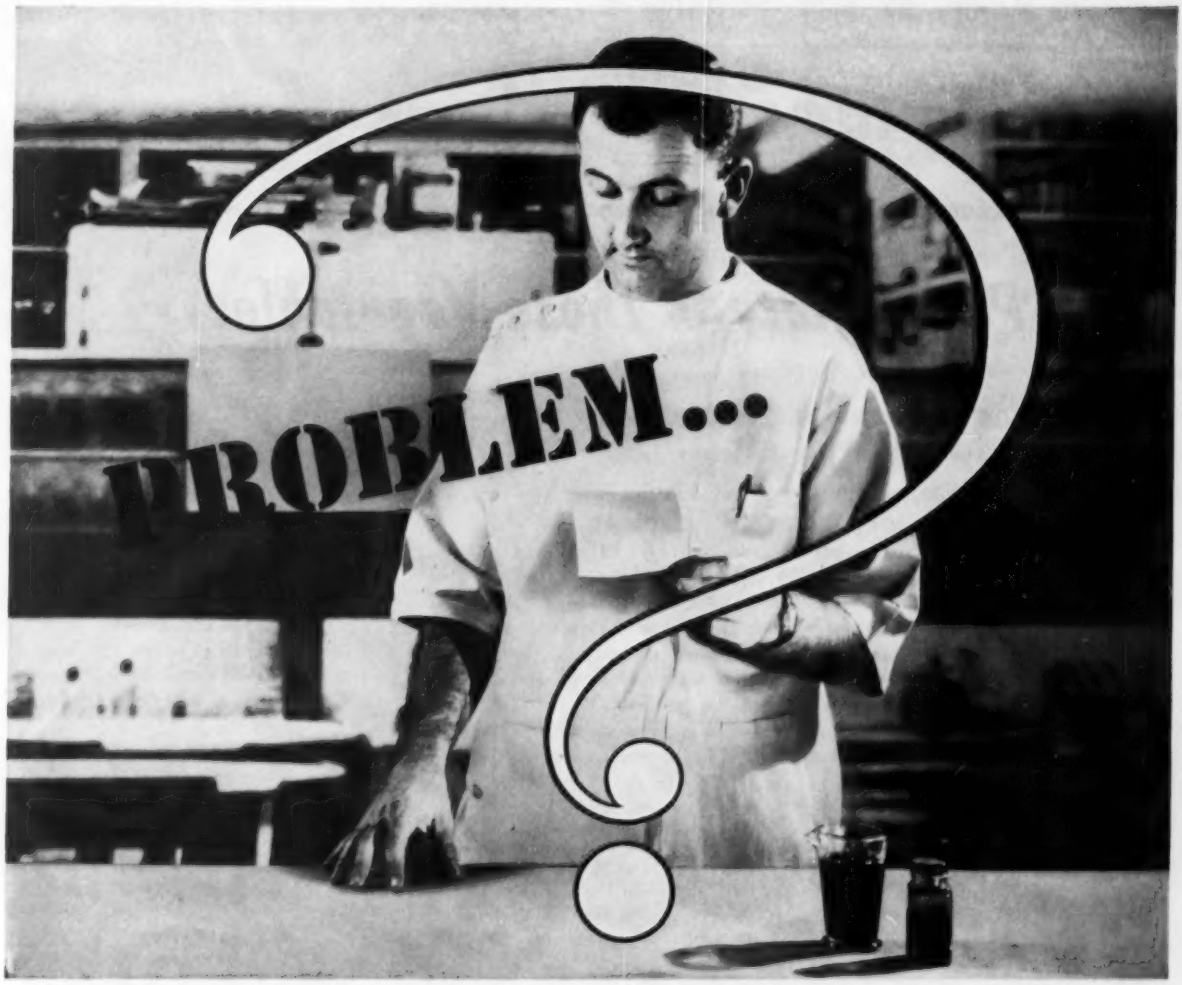
Despite many inconveniences and difficulties encountered because the hospital had not been originally designed for such a service, the experiment has been rewarding in showing that the idea was appealing and accepted wholeheartedly by the patients. In this tentative trial, the central dining room service was optional for the patients. A majority chose to take their meals in the common dining room, and they were most enthusiastic about it. It has been observed that most of them complained less of the hospital food, had better appetites, and enjoyed their meals much more than when they were served prepared trays in their own rooms. This group of patients demonstrated that communal dining produced a striking change in the mental attitude toward illness after operation.

In the planning and design of hospitals for the future, such a central dining room—more particularly, a cafeteria—should be a feature of each floor for surgical patients. It should be designed also to serve as a recreation room between meals and in the early evening. The small dining tables (for four persons) can be used for card games and letter-writing and for conferences with visitors.

With a central cafeteria dining room available, all but the most feeble or crippled patients would be expected to go there at mealtime and to select their own food. For patients requiring some special diet, for example, those with diabetes, special diet lists as to allowed foods, or, if necessary, specially prepared trays, would be available. In most instances, the patient would be capable of carrying his own tray to the table where he would join others for a sociable meal. Maids or attendants would be on duty in the dining room to aid those who were not able to carry the tray. After completion of the meal, the patient would, when able, carry his dishes to the dumb-waiter. The idea of this "self-service" is to provide exercise and encourage beneficial activity.

Although the primary purpose of the changes here suggested is to foster and stimulate the positive psychologic attitude of desire to get well rapidly, and to augment the activity so essential to complete recovery, such modifications in hospital design would also present great advantages for the hospital from the standpoint of more efficient use of personnel and, hence, of economy. The reduction of the average duration of hospitalization by even one day represents an enormous saving to the hospital and to the community in that more patients can be accommodated with the same overhead costs. Nursing personnel is used more efficiently, since the work of the nurses is confined largely to supervision and instruction and to emergencies requiring special skill, while the menial tasks are taken over by ward helpers and maids, and the patients attend to many of their own personal needs.

If proper attention is given by the professional staffs and by those responsible for the remodeling and building of hospitals to the changes that have occurred and the advances that are probable as part of a developing trend, it should not be difficult to elicit the proper cooperation from architects, who have recently placed so much emphasis on dynamic concepts of "functional design." With the proper interest and cooperation of all groups concerned, we should begin to plan our hospitals for the medical and surgical practices of the Twentieth Century.



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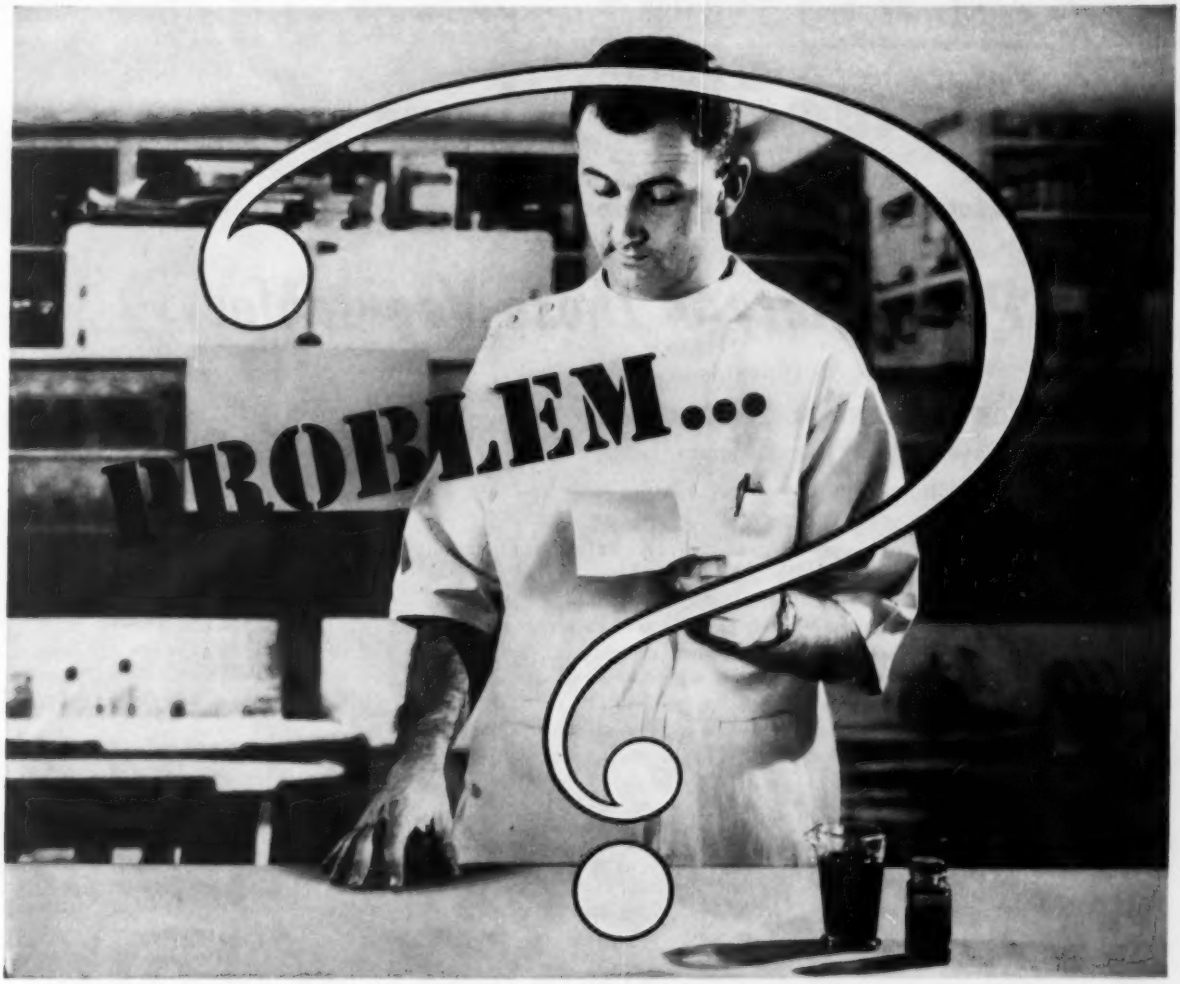

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Put Variety in Those Vegetables

JOAN M. ROCK and **DORIS H. ZUMSTEG**
Chicago *Teaneck, N.J.*

VEGETABLES seem to rate less attention than other foods in institutional food service for the same reasons, perhaps, that they should rate extra-special care: Vegetables are relatively cheap and vegetables offer plenty of variety. Maybe because they aren't as expensive as meats and many meat substitutes, vegetables aren't accorded the time and attention necessary to make them more than just something that goes with two meals out of three.

The quality products in vegetables —fresh, fresh-frozen, canned and dried—along with streamlined equipment designed for their preparation, makes possible excellently cooked vegetables in every institutional food service situation.

Hospital food departments have come a long way, keeping step with the entire food service field, in offering well cooked, tasty, colorful vegetables in spite of the many serving problems that are not encountered in other types of food service establishments.

Cooking vegetables just until they are crisp-tender in the least amount of water is as correct today as it was the day when cooking concepts emerged from the overcooked, sodden vegetable era.

QUICK TRANSFER TO SERVING PANS

When large loads of fresh and frozen vegetables are boiled, sufficient water must be allowed to keep the vegetables boiling agitatedly. However, they should be transferred to serving pans as soon as the cooking process is completed to avoid their becoming tasteless and poor in color and of lower nutritional value. A recent Cornell Experiment Station bulletin[1] states that "nearly all vegetables studied retained over 50 per cent ascorbic acid, thiamine and riboflavin when cooked . . . using only enough water to cover and cooking until just tender."

While cooking vegetables, fresh and frozen, in the smallest batches possible in relation to the speed of service is accepted by food managers generally, many overlook the necessity for the same procedure with canned and dehydrated vegetables, which are often subjected to long periods of standing with proportionate flavor and color loss as a result.

It is of vital importance to note that in cooking fresh vegetables in a utensil on the range top, there is more loss of ascorbic acid from 20 pound lots than from 5 pound lots.[2]

Where the 40 quart and larger jacketed kettle is used, it is most important that not too many vegetables be placed in it at once. Too heavy a load, especially of canned vegetables, since they are already cooked when placed in the appliance, will cause mashing or other unsightliness. By the time the last 20 portions are removed, they will be a sorry sight and certainly not an inducement to improve jaded appetites.

The newer installation of table type tilting jacketed kettles from 1 quart size up are a step toward smaller batches of vegetables with the least possible effort and expenditure of time. Two or more varieties can be going at one time, or staggered batches of a single variety can be in various stages of preparation. The 10 quart size kettle is considered to be quite practical.

While discussing the cooking of relatively small batches of vegetables, we should not overlook the use of the pressure cooker. Under certain conditions the 6 and 8 quart pressure cookers have proved to be the answer to quick and successful vegetable cookery in small hospitals or in decentralized units of large institutions.

The steamer is a favorite in many hospitals for potatoes, beets, all kinds of squash (excepting perhaps zucchini), kohlrabi, yams, turnips and other more robust items. Because the steamer does its job so well and with so little "watching," food in the steamer is likely to be forgotten and permitted to be cooked too long. (Busy chefs or disinterested workers are a problem in anybody's hospital.)

When vegetables are steamed without added water, there is higher vitamin retention than there is when vegetables are boiled. However, the vitamin retention, along with palatability and color, is significantly lower as pressure is increased.[3]

In restricted diets it is more essential than ever to avoid "cooked-to-death" vegetables. In some diets where there is no possibility of a "cover-up" job by way of seasoning, butter or sauce, the colorless, tasteless vegetable can be pretty hopeless for the unlucky patient.

Dehydrated vegetables have been vastly improved over the early war-

[1] Cornell University Agricultural Experiment Station. Bulletin 891. Vitamin Retention and Palatability of Certain Fresh and Frozen Vegetables in Large-Scale Food Service. June 1953, p. 31.
[2] *Ibid.*, Table 3, p. 20.
[3] *Ibid.*, pp. 28, 29.

GREEN BEAN AND VEAL STEW

Try a "reverse order" of assembly for arousing interest . . . potatoes on top of stew for a pleasing change. The small recipe suggests an idea that can be adapted to a formula for two, 20 or 200 servings.

1 lb. boned veal shoulder	1 T. sugar
3 cups cold water	1 tsp. salt
2 tsp. monosodium glutamate	2 T. vinegar
2 lbs. green beans	¼ tsp. summer savory
3 T. butter or margarine	1 T. chopped parsley
3 T. flour	⅛ tsp. pepper

Cut veal in ½ inch pieces. Add cold water and 1 teaspoon of the monosodium glutamate. Bring slowly to boil; lower heat; simmer 1 hour. Wash beans; break off tips; remove strings, if any. Break into 1 inch pieces; add to veal; cover; cook 25 minutes, or until tender. Melt butter or margarine; blend in flour, sugar, salt, and remaining monosodium glutamate. Measure liquid from green bean mixture; add enough water to make 4 cups; add to flour mixture with vinegar. Cook, stirring, until smooth and thickened; return to green bean mixture. Add savory, parsley and pepper. Cook, uncovered, over low heat 15 minutes. Top each serving with generous mound of mashed potatoes. Makes 6 servings.

POTATO CHEESE CROQUETTES

Multiply by 2 or 20, the "control" is in the potatoes and liquid.

2 cups cold (leftover) mashed potatoes	Salt, to taste
1 egg, beaten	¾ tsp. monosodium glutamate
1 cup grated Cheddar cheese	½ cup fine dry bread crumbs
½ cup milk	

Break up potatoes. Beat egg in blender until frothy. Add potato pieces gradually, beating at medium speed until blended. Stir in cheese, salt and monosodium glutamate. Shape as desired. Dip into crumbs, then into milk, and again into crumbs. Fry in shallow hot fat until golden brown on all sides. Makes 6 servings.

QUICK "ROAST" POTATO BALLS

Turn canned potatoes and liquid or small whole peeled potatoes into bowl or dish; sprinkle with salt and monosodium glutamate. Let stand 10 to 15 minutes. Drain well. Cook, a few at a time, in deep hot fat (375°F.) about 3 minutes or until tender, golden and crusty. Drain on absorbent paper. Sprinkle with salt, pepper and monosodium glutamate and serve hot.

time product. They can be time and labor saving and, when properly prepared, delicious adjuncts to many main courses. But proper preparation must be impressed upon the cooks. Manufacturers of these products usually have the most explicit and easy-to-follow directions on the package or in package inserts. The supervisor should see that the employe understands the directions and that he follows them to the letter if the result is to be satisfactory.

Fried vegetables and vegetable fritters can be such a pleasant variation on the general theme. French fried potatoes are part of normal diets, very happily from the standpoint of both the patients and the staff. But if they cannot be right—hot, crisp and tender—they should not be served at all. It is no discredit to any dietary service department not to be able to serve fried foods because of lack of adequate cooking and serving facilities, but it is a step in the wrong direction to serve inedible fried foods. Crisply fried young squash "sticks," eggplant or onion rings are enough to "pick up" any hospital employe after a hard day's work, while "tired," limp or greasy products can cause no end of grumbling. Again, it's a matter of cooking the food in small batches, as needed, with proper attention accorded the condition of the fat, its temperature, and the capacity of the fry unit.

It is interesting to note that, in keeping with the fast moving frozen food industry, U.S. standards for grades of frozen French fried potatoes have been issued.[4]

Use of the oven in vegetable cookery should not be overlooked. The baked white potato is served often, but the baked sweet potato, yam and baked acorn and Hubbard squash are neglected. (Almond-glazed sweet potatoes, incidentally, are nice ham or turkey accompaniments.) Baked until soft, split or cut in portions, depending on the vegetable, then with a dab of butter added, these vegetables can be good eating and labor saving to boot. A word of caution: Overbaking of starchy vegetables and then failure to open the skin when done results in sogginess.

When the cooking of vegetables considerably ahead of time cannot be avoided, the use of hot food servers can be an answer to preventing cooling, shrinkage, drying out and loss of flavor, to some degree, of all foods. These appliances come in various sizes and models, including mobile units.

Seasoning is more important in vegetables than in many other foods because most vegetables are bland in flavor, soft in texture, and cooked in water or steam. Also, there has been an inevitable loss of flavor owing to shipping and processing.

Most cooks agree that salt must be added during the early stages of cooking, but, unfortunately, they let it go at that. Frequently it is necessary to add extra salt along with pepper or other spice at serving time.

(*Continued on Page* 116)

[4]U.S. Department of Agriculture. Bulletin, Food Supplies and Markets, Nov. 19, 1954, p. 5.

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(*Continued From Page* 114)

When all vegetables for both normal and salt-free diets are cooked together, it is essential that the food supervisor sees that seasoning is added consistently and in proper amounts to the normal diet vegetables after sufficient vegetables have been removed for the restricted diet trays.

TO INCREASE PALATABILITY

Dietetic canned products are a simple answer to variety in vegetables for restricted diets but, because they are so easy to use, they should not be set aside with no attention at all. Addition of monsodium salt, sweet or salt butter, ground onion, monosodium glutamate, or sauce within the limitations of the diet can do much for palatability.

The use of monosodium glutamate in all vegetable cookery has become practically standard in hospital food service. It takes delicious natural flavors to restore appetites dulled by illness, and the function of monosodium glutamate is to restore the natural flavor that was in the growing vegetable in the form of glutamic acid. A white crystal, monosodium glutamate is not difficult for the cook to use; he adds it right along with salt and pepper in the ratio of about 1 ounce of monosodium glutamate to 40 to 50 pounds of vegetables. Monosodium glutamate adds no flavor of its own nor does it change the flavor of the food at all; it brings out the natural flavor and *holds* it on the steam table or food cart, certainly an important factor in hospital food service.

Moreover, monosodium glutamate is achieving recognition for its flavor-emphasizing qualities in the special diet kitchen. Monosodium glutamate contains about one-third the sodium content of ordinary table salt. When special diets call for as little salt as possible, monosodium glutamate offers an ideal supplemental seasoning to make such foods more palatable. In salt-limited diets, monosodium glutamate can be used in place of, or along with, a smaller amount of salt or, in some instances, no added salt to give a much better tasting dish at a lower sodium intake level.

WATCH WHITE SAUCE PREPARATION

The old prejudice against the use of any spice but salt in the hospital kitchen, happily for the patient, has given way to the judicious use of spices which are not too numerous or too complicated to use and which add much to the enjoyment of the food. Just as sage, savory and thyme are taken for granted in poultry cookery, and dry mustard and dill or celery seed in salads, a touch of curry powder in panned cabbage or a tinge of garlic flavor (either fresh or garlic salt) in wax or snap beans can add flavor interest with little extra trouble.

White sauce can be so useful in conjunction with vegetables that it is too bad when white sauce is not at its very best or used to the best advantage.

The basic principle of preparing the sauce is known to everyone in the food service industry; it is a matter of supervision rather than know-how. The use of dried milk solids is easy and also reduces food cost. Simple variations of basic white sauce, such as the following, can do much to set off vegetables to advantage yet not require appreciable added labor:

Chopped chives lightly cooked in the fat, chopped parsley or a pinch of thyme or marjoram in the white sauce vastly improve peas and lima beans.

A cheese sauce prepared from the white sauce plus grated *sharp* cheese is basic for side orders of vegetables as well as vegetable casseroles.

Mustard sauce can give flavor interest to snap beans, cabbage and greens. It is a matter merely of adding dry mustard to the white sauce.

The addition of chopped eggs or slivered nuts such as almonds or filberts do much for the appearance, texture and general enjoyment of cauliflower, Brussels sprouts or cabbage wedges.

We would not be doing a complete job of discussing cream sauces for vegetables if reference to the use of canned cream soups as sauces were omitted. Concentrated cream of mushroom and cream of celery soups serve as time saving, labor saving, portion

CARROTS POLONNAISE

Pressure saucepans, operated in a series, may be a solution for smaller institutions. Vegetables can be cooked just tender and practically to order.

2 lbs. carrots (Julienne cut)
½ cup water
½ tsp. salt
¼ to ½ tsp. monosodium glutamate
6 T. butter
3 T. fine dry bread crumbs
Few drops lemon juice
1 T. finely minced parsley

Place carrots in pressure saucepan with water, salt and monosodium glutamate. Cook at 15 pounds pressure for 6 to 8 minutes. Melt butter over direct heat; boil until it browns slightly. Add bread crumbs; cook until crumbs are brown and butter stops bubbling; add lemon juice; pour over drained hot carrots. Sprinkle with parsley. Serves 6.

FRENCH FRIED POTATOES

Whether you use 12 ounce or 10 pound packs of potatoes, here is the "quick pattern" for French fries:

2 packages (12 oz.) quick-frozen French fried potatoes
¼ tsp. monosodium glutamate

Place potatoes in shallow pan; sprinkle with monosodium glutamate. Place in moderate oven (350°F.) for about 15 minutes, or until thoroughly heated; stir once or twice during heating.

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controlled uniform sauces which also can be varied for delicious results.

Because some vegetables show pronounced vitamin loss from holding on the steam table, there is the nutritional angle to be considered, as well as flavor and color loss.

Vitamin loss of some vegetables and color and flavor of most vegetables suffer from holding on the steam table, making quick serving mandatory.

Sufficient butter and sauce should be added carefully and sauce that has become unduly thick, crusty and distasteful in other ways should be improved or replaced.

Dietitians who use heated dish service advise that some of the liquid should always be served along with the vegetables. The need for serving the liquid with all vegetables is indeed imperative. The *Journal of the American Dietetic Association* for December 1944 states that ". . . in serving with a slotted spoon, the loss of all of the vitamins is considerable. . . ."

The busy schedule of hospital food service with its myriad problems may require so much emphasis on labor, special diets, and just everyday planning that vegetables settle down to peas, carrots, green beans, corn, potatoes, celery, tomatoes, spinach and beets. It is too bad, too, when staff menus are restricted to vegetable varieties served to patients. Following are some suggestions which can serve as a check list for broadening the menu, using readily obtainable vegetables to set off good main dishes.

A quick look at the market focuses attention on the relatively newer items, and some oft-overlooked ones, that can improve the quality and variety of vegetables on the menu and often reduce labor costs.

SAVING TIME ON POTATOES

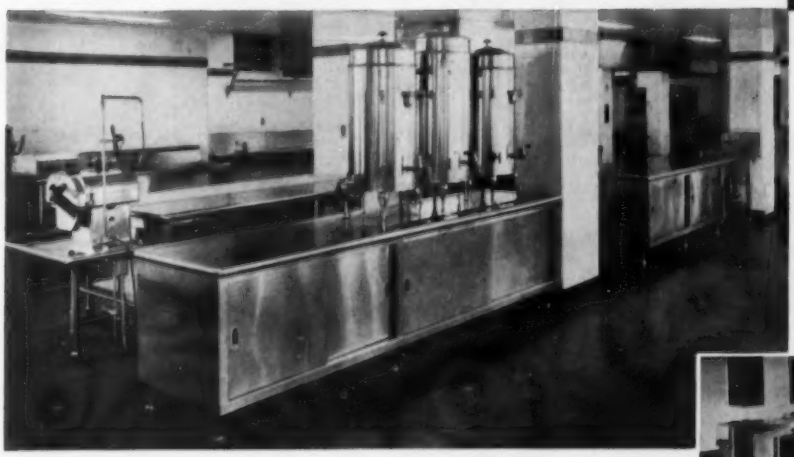
Handling potatoes takes so much of the time allotted to vegetable preparation that it might be wise to investigate the possibilities of the ready-to-cook or partially cooked offerings. Frozen potatoes cut in French fry or dice cut come ready for use in five pound waxed paper bags packed six per case. Frozen potato patties are packed in six cartons of 32 patties per case. Dehydrated or frozen shredded potatoes make freshly mashed potatoes a possibility, even for the last few people who go through the cafeteria line.

(*Continued on Page* 120)

"25% more people served... 10% reduction in kitchen help"

FIRST-YEAR RECORD OF WILSON MEMORIAL HOSPITAL'S BLICKMAN-BUILT FOOD SERVICE INSTALLATION

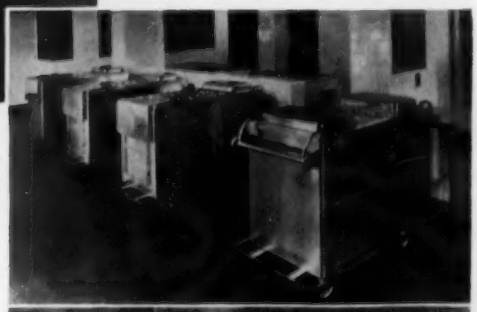
MR. ROBERT L. ECKELBERGER
Administrator, Wilson Memorial Hospital



Left: Main kitchen, showing stainless steel coffee urns and stand in foreground, stainless steel vegetable preparation and cooks' tables in background.

Below: Group of electrically-heated stainless steel food conveyors with seamless top and body construction. Hot foods are transported in bulk from main kitchen to individual serving pantries.

Bottom: Salad preparation area, showing stainless steel sink, refrigerator and work table with round-corner drawers.



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(*Continued From Page* 118)

A word about mashed potatoes in general: When the unpredictable happens and mashed potatoes do have to languish on the steam table longer than usual, the addition of some warm milk and a shake or two of monosodium glutamate plus a vigorous stirring will be a great help in restoring flavor and lightness. The use of commercial products for maintaining the whiteness of potatoes is a help to the cook and avoids any long soaking period prior to cooking.

Although most institutions use canned sweet potatoes with resulting satisfaction, dietitians are likely to overlook the value of canned white Irish potatoes for creaming, pan roasting and potato salad. There are good brands of pure white, tender, uniformly sized small potatoes ready for finishing off at a twist of the can opener.

The canned food industry has a whole battery of suggestions for perking up the vegetable column on the menu. Not all are packed in No. 10 tins, but then, not always is No. 10 size necessary or desirable.

Broiled-in-butter mushrooms are on the expensive side but can add real glamour and flavor in special cases.

Whole slender butter beans are a change from cut green beans and so are French cut green beans.

Celery hearts, artichoke hearts, and *hearts-of-palm* marinated for several hours are unusual and savory adjuncts to either the vegetable, cold meat or salad plate.

Not a vegetable as such, but very good in combination with the vegetable salad or slaw, is canned *tomato aspic.* It is easy to use and tasty.

COMBINED IN CANS

For soups, creaming and casseroles, the canned *combination of vegetables* saves considerable kitchen work and "comes to the aid of the party" in no uncertain terms.

Canned *soy sprouts* needn't be relegated to Chinese dishes alone. As part of a tossed vegetable salad and instead of rice or noodles with cooked meat, they can provide nice variety.

Stewed tomatoes, peppers and onions in cans can be the basis for many sauces, delicious by themselves, as a change from plain stewed tomatoes.

Vacuum-packed *French fried onions* can lend "oomph" to the steak in the staff dining room without sending the chef into hysterics downstairs. *French fried potato sticks* are excellent on Sunday night supper plates.

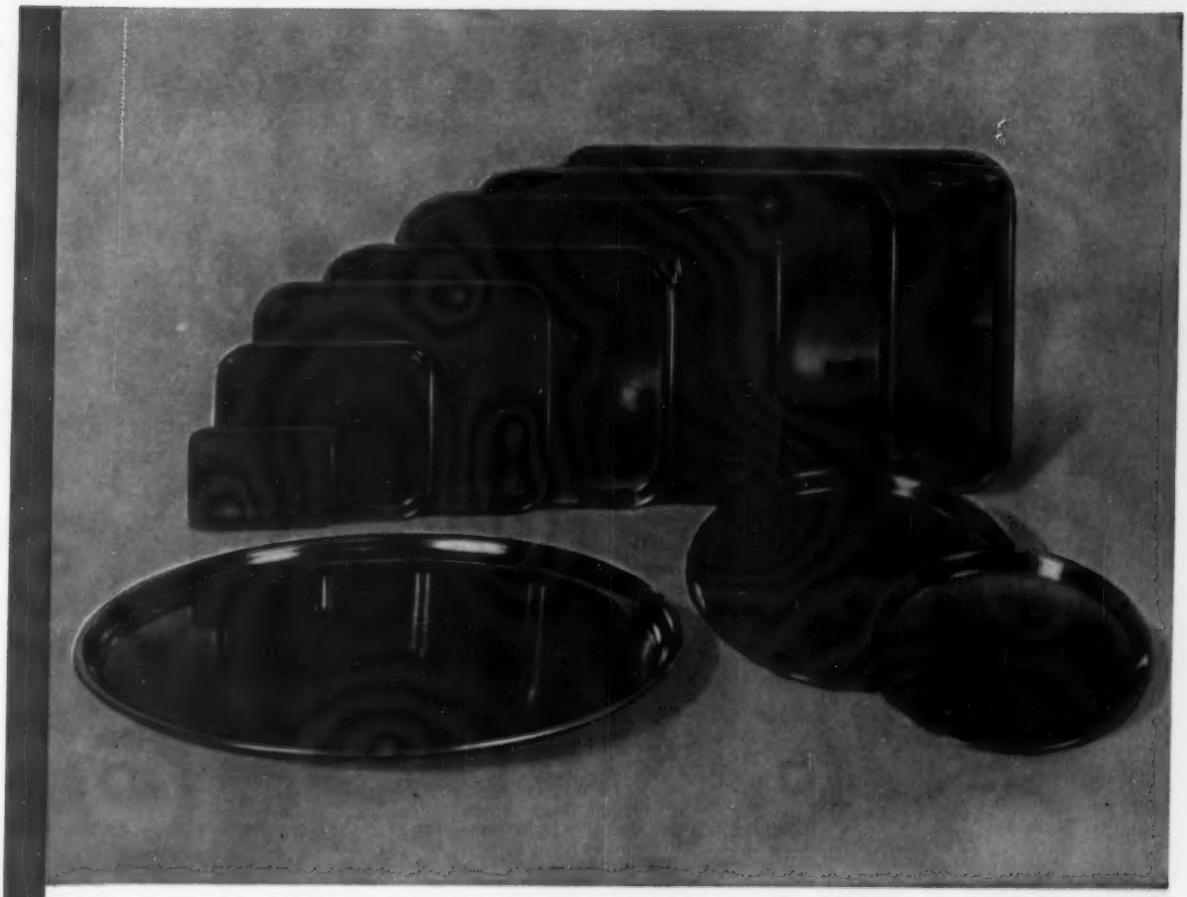
Canned *okra* and okra and tomato combined are useful in "made" dishes and as a vegetable in areas where okra is popular.

Canned *tomato purée* and special sauces as well as soups are handy ingredients for made vegetable dishes. Brown gravy or gravy with mushrooms is good to have in an emergency when the need arises for meaty gravy on meatless main courses.

Fresh *kale, okra, spinach, beet greens,* and *snap beans* are as delicious panned as cabbage is. Trim and shred the leafy vegetables, slice the beans lengthwise and the okra diagonally crosswise. Melt fat (don't overlook bacon drippings) in a large fry pan. Add the vegetables and seasoning and put on a cover to hold in the steam. Cook over low heat until just tender. Move the pan to prevent sticking.

Turnips were meant for something beside cubing and vigorous mashing with or without potatoes. Delectable *Canadian rutabagas* can be attractive when cut into sticks, cooked, then

(*Continued on Page* 122)



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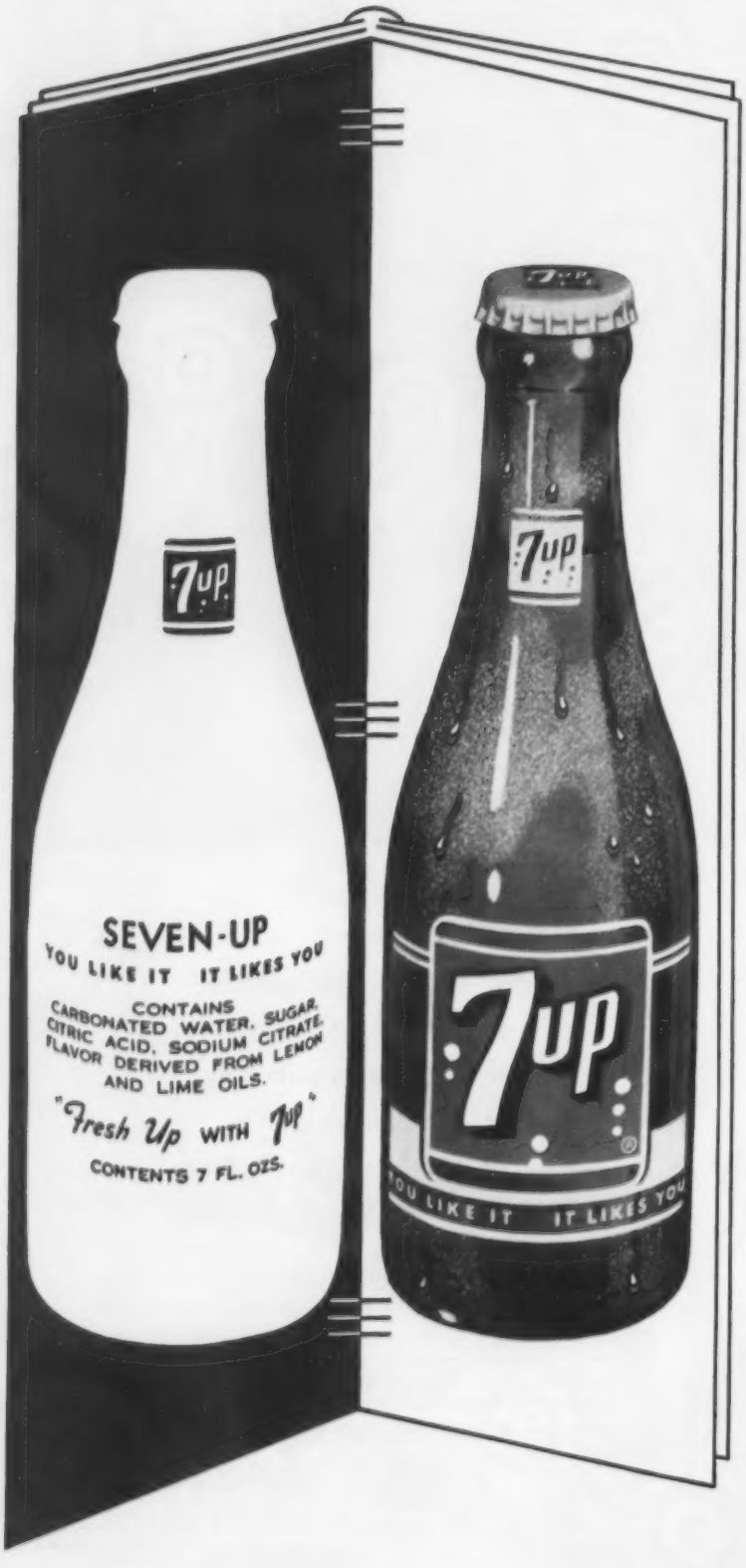

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If you hanker for a cool, clean taste . . .
If you want a quick, refreshing lift . . .
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reheated in a combination of melted butter or margarine, grated onion, chopped parsley, and lemon juice.

Rutabagas glazed with brown sugar or honey and butter are a close second to sweet potatoes flavorwise.

Escalloped turnips and apples are a wonderful foil for ham or fresh pork or can be a luncheon dish, topped with sausage or Canadian bacon.

Frozen, fresh or canned *peas* are the better for occasional combining with tiny onions or with sliced fresh mushrooms, light cream, and the slightest suggestion of grated onion.

Squash usually gets to the tray or table in the form of Hubbard or crooked-neck varieties.

Zucchini squash is as delicately flavored as any vegetable can be, but panned quickly in olive oil with onion rings and a few peppercorns with or without tomato paste and green peppers is something else again.

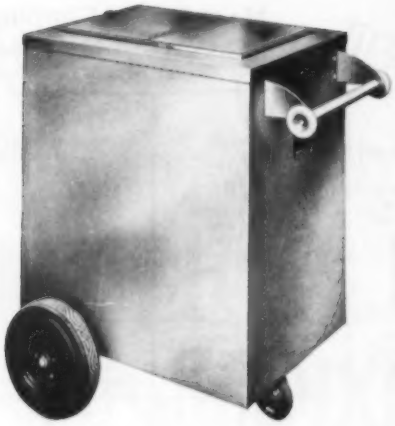
Butternut squash gets its share of the limelight only in butternut squash-conscious sections of the country. It deserves wider coverage. The skin is smooth and soft, so paring is no problem. It may be spread with butter, seasoned and broiled, baked, boiled or steamed—but woe to the one who lets it cook away in too much water; the rich golden vegetable deserves better treatment.

Fritters are good for a change as a main dish or as a vegetable. Puff balls bobbing around in the deep fryer or thin, crisp, golden fritters sizzling in the pan each have their devotees, but hot they must be and crisp, too, and therein lies the problem for food service supervisors. Limitation of space and facilities has made it necessary to offer fritters in one or two dining units at a time, rather than throughout the entire hospital. By the way, chopped nuts are an interesting addition to vegetable or parsnip fritters.

FORM LENDS VARIETY

Mere form can lend variety to vegetable service. Whether fresh, frozen or canned, variation among mashed, cubed, shoestring, French cut, sliced, chopped and whole vegetables can add interest.

By now, someone is thinking, "All right, be specific!" So specific we are by offering some of our pet vegetable recipes that are just different enough to be interesting but simple enough to keep the kitchen crew pacified. (See pages 114 and 116.)



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Menus for May 1955

Mary Louise Clippinger
Director of Dietetics
Aultman Hospital, Canton, Ohio

1 Apricot Nectar Soft Cooked Egg, Toast • Chicken Alphabet Soup Breaded Veal Cutlet With Tomato Sauce Escalloped Potatoes Buttered Peas Citrus Fruit Salad Ice Cream With Butterscotch Sauce • Cream of Mushroom Soup Frankfurter in Spanish Sauce on Roll Potato Salad Purple Plums Sugar Cookie	**2** Stewed Prunes Bacon, Cinnamon Toast • Vegetable Soup Ham à la King on Toast Rounds Julienne Green Beans Blueberry Crisp With Whipped Cream • Savory Swiss Steak Snowflake Potatoes Stewed Tomatoes and Diced Eggplant Jack Straws Cinnamon Applesauce	**3** Grapefruit Half Poached Egg, Toast • Navy Bean Soup Toasted Bacon, Tomato and Lettuce Sandwich Fluted Potato Chips Celery Sticks Filled With Cheese Frosted Brownies • Irish Stew With Cornmeal Dumplings Buttered Broccoli Orange and Pecan Gelatin Salad Butterscotch Cream Pie	**4** Prune Juice Sausages, Bran Muffins • Minestrone Soup Spaghetti With Italian Sauce, Parmesan Cheese Asparagus Tips Relish Plate Citrus Fruit Cup • Cranberry Juice Southern Baked Chicken Giblet Gravy Honey Glazed Yams Paprika Pearl Onions Peach Crumble With Whipped Cream	**5** Sliced Oranges Bacon, Fruit Twist • Bouillon Beef-Noodle Casserole Zucchini Florentine Tomato and Cottage Cheese Salad Apricot Whip With Custard Sauce • Tomato Juice Sautéed Liver With Brown Gravy O'Brien Potatoes Buttered Carrot Rings Haystack Salad Heavenly Hash	**6** Pineapple Chunks Soft Cooked Egg, Toast • Clam Chowder Western Omelet Buttered Peas Creamy Coleslaw Grapefruit Lemon Puff • Creamed Asparagus Soup Baked Tuna and Vege- table Casserole With Biscuit Crust Lima Beans Tomato-Olive Aspic Chocolate Nut Ice Cream
7 Blended Juice Shirred Egg on Waffle • Mulligatawny Soup Chicken Tetrazzini Brussels Sprouts Fresh Fruit Salad With Grenadine Sauce Coconut Pudding • Grilled Ham Slice With Orange Sauce Rissoli Potatoes Mexican Corn Head Lettuce Wedge Fruited Jello With Whipped Cream	**8** Cherry Juice Sausage Patties, Buns • Grape Juice Roast Sirloin of Beef Stuffed Baked Potato Buttered Wax Beans Beauty Salad Graham Cracker- Pineapple Pudding • Chicken Noodle Soup Welsh Rabbit Over Broiled Tomato on Toast Points Asparagus Spears Molded Fruit Salad Peanut Oatmeal Cookies	**9** Stewed Apricots Poached Egg on Toast • French Onion Soup With Croutons Spanish Rice, Bacon Vegetables Macedoine Fruit and Cauliflower Salad Butterscotch Ripple Ice Cream • Baked Pork Chop Apple Dressing Sweet Potato Surprise Spinach au Gratin Cherry Crisp With Nutmeg Sauce	**10** Grapefruit Sections Bacon, Raisin Toast • Split Pea Soup Macaroni and Cheese Casserole Broiled Tomato Half Tossed Spring Salad Lemon Snow With Cherry Garnish • Cream of Chicken Soup Epicurean Hamburger Hot German Potato Salad Celery Sticks Fresh Fruit Cup	**11** Applesauce Soft Cooked Egg, Toast • Vegetable Juice Chicken à la King on Toast Points Julienne Carrots Banana Nut Salad Frozen Pink Centered Peach Half • Orange Juice Roast Shoulder of Veal, Gravy Potato Casserole au Gratin Buttered Green Beans French Apple Pie	**12** Stewed Fruit Compote Bacon, Date Muffins • Cream of Asparagus Soup Frizzled Chipped Beef With Scrambled Eggs Pan Browned Potatoes Sliced Tomato and Cucumber Salad Boston Cream Pie • Corn Chowder Pepper Steak Over Egg Noddles Buttered Sliced Beets Strawberry Ice Cream
13 Orange Juice Scrambled Egg on Toast • Tomato-Rice Soup Cream Cheese and Olive Sandwich on Whole Wheat Bread Potato Chips Deviled Egg Salad Blitz Torte • Salmon Croquettes, Parsley Sauce Diced Potatoes Buttered Peas and Sautéed Mushrooms Raspberry Salad Fudge Pudding	**14** Banana Sausages, Corn Muffins • Creamed Vegetable Soup Barbecued Pork on Sandwich Bun Waldorf Salad Gingerbread-Pear Upside Down Cake • Beef Pot Roast, Vegetable Gravy Oven Browned Potato Creamed Corn Perfection Salad Lemon Filled Eclair	**15** Grapefruit Juice Ham, Pineapple Muffins • Creamed Spinach Soup Baked Stuffed Green Peppers Broiled Tomato With Mushroom Cap Layered Gelatin Salad Blueberry Buckle • Country Fried Steak Duchess Potato Succotash Marinated Asparagus Salad Sesame Seed Rolls Sliced Pineapple	**16** Baked Apple Scrambled Eggs, Toast • Beef Broth With Seashell Noodles Corned Beef Hash Chili Sauce French Fried Potatoes Apple Goodie With Whipped Cream • Roast Leg of Lamb, Mint Jelly Parslied Potatoes Julienne Carrots Pink Pear and Cream Cheese Salad Maple Nut Ice Cream	**17** Grape Juice Bacon, Biscuits • Orange-Mint Cocktail Chicken Fricassee Over Fluffy Rice Broccoli Spears With Buttered Crumbs Cranberry Jewel Salad Banana Cream Pie • Ham Loaf, Mustard Sauce Broiled Marshmallow Sweet Potato Whip Spinach Soufflé Cheese Apple Crisp	**18** Stewed Prunes Bacon, Doughnuts • Vegetable Juice Seafood Newburg in Pattie Shells Buttered Green Beans Peach-Cheese Salad Baked Raisin Rice Pudding • Baked Ham With White Raisin Sauce Baked Corn Pudding Paprika Cauliflower Strawberry Soufflé Salad Peach Lattice Pie
19 Orange Slices Sausages, Toast • Spaghetti Caruso Brussels Sprouts Lettuce With French Dressing Bread Sticks Tutti Frutti Ice Cream • Blended Citrus Juice Broiled Veal Chop Cranberry Glaze Hashed Potatoes Stuffed Onions Melon Ball Salad Marble Cake	**20** Stewed Apricots Soft Cooked Egg, Toast • Tomato Bouillon Broiled Mackerel Creamed Peas Panama Salad Date Bread Pudding • Tuna Mousse Deviled Eggs Over Spinach Noodles With Cheese Sauce French Fried Eggplant Lemon Sponge Cake	**21** Peach Nectar Poached Egg on Toast • Vegetable Soup Fluffy Turkey Turnovers, Giblet Gravy Green Bean Creole Waldorf Cabbage Salad Cranberry Meringue Pie • Shepherd's Pie With Fluted Potato Border Asparagus Spears Pineapple-Prune Salad Baked Crumb Custard	**22** Banana Ham, Sticky Pan Buns • Roast Pork Loin, Cider Gravy Escalloped Sweet Potatoes and Apples Relishes Cherry Ice Cream • Cream of Chicken Soup Chili With Macaroni Buttered Wax Beans With Green Pepper Tomato-Celery Aspic Green Gage Plums	**23** Applesauce Chipped Beef on Toast • Corned Beef With Horseradish Sauce Steamed Cabbage Grapefruit-Cheese Salad Apricot Halves • Meat Croquettes, Pickle Relish Gravy Creamed Diced Potatoes Glazed Cinnamon Carrots Beatrice Vegetable Salad Devil's Food Cake With Mocha Frosting	**24** Orange Halves Soft Cooked Egg, Toast • Pineapple Juice Cheeseburger on Bun French Fried Potatoes Pear, Pickle, Pea Salad Black and White Pudding • Roast Duck Celery-Apple Dressing Waldorf Stuffed Potato Tomatoes and Okra Banana Salad Lime Sherbet
25 Prune Juice Bacon, Pecan Rolls • Beef Broth Julienne Swedish Meat Balls Fluffy Irish Potato Cottage Cheese Salad Golden Cup Cake With Orange Icing • Lamb Curry Over Crispy Noodles Cheddar Carrots Sliced Cucumber Salad Fudge Sundae	**26** Orange Juice Sausages on Waffles • Braised Shortribs, Horseradish Sauce New Potatoes Steamed Cabbage Wedge Spiced Apple Salad Norwegian Prune Pudding, Lemon Sauce • Chicken Gumbo Soup Ham-Broccoli Roll Egg Sauce Corn Fritters, Sirup Tomato Tower Salad Nutmeg Applesauce	**27** Strawberries Poached Egg on Toast • Cream of Celery Soup Cheese Fondue Fresh Tomato Sauce Asparagus Spears Carolina Salad Danish Apple Pudding • Tomato Juice Baked Perch Fillets Lemon Butter Snowflake Potatoes Wilted Endive Peach-Bonbon Salad Coconut Layer Cake	**28** Baked Apple Bacon, Hot Biscuits • Creole Soup Cold Sliced Corned Beef With Mustard Swiss Cheese, Rye Bread Club Luncheon Salad Peaches and Cream Pudding • Veal Birds, Mushroom Gravy Chantilly Potatoes Breaded Eggplant Molded Bing Cherry Salad Fresh Fruit Cup	**29** Apricot Nectar Pancakes With Sirup • Roast Beef Franconia Potatoes Buttered Carrot Strips Cabbage, Pineapple and Marshmallow Salad Fresh Plum Cobbler • Cream of Vegetable Soup Toasted Bacon and Cheese Sandwiches Buttered Lima Beans Sliced Tomato Salad Black Walnut Ice Cream	**30** Orange Juice Scrambled Eggs, Toast • Broiled Liver, Onions Whipped Potatoes Fresh Tomatoes au Gratin Lettuce Wedge With 1000 Island Dressing Apple Cobbler With Lemon Sauce • Pineapple Juice MacGregor Casserole Asparagus Spears Molded Strawberry Salad Fresh Fruit Cup
31 Banana, Bacon, Maple Rolls • Pork Chow Mein on Rice With Noodles, Soya Sauce, Julienne Carrots, Tossed Vegetable Salad, Fresh Peaches • Baked Stuffed Meat Loaf, Mushroom Sauce, Lyonnaise Potatoes, Diced Beets in Orange Sauce, Chocolate Tapioca Pudding With Marshmallow Garnish					

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Selecting and Buying Paint

(*Continued From Page 74*)

facturer. It shall show minimum settling, and any settling shall be soft and easily redispersed after being stored in an unopened container for a minimum of six months.

4. The paint shall, after application, be at least equal in freedom from objectionable odors to the standard rubber-base (latex emulsion), water-base paints. It shall be possible to efface smudges, pencil marks, grease pencil marks, and ink after the paint has dried at least seven days by scrubbing with a cellulose sponge and a mild detergent, using two tablespoons of powder per gallon of warm water, and the resultant effect when dry shall be free of streaks. It shall be possible to wash this paint not less than eight times before repainting is necessary.

While testing may be performed as required by appropriate federal testing specifications, it should not be necessary to do much of this on standard products of reputable manufacturers. The penalty for failure to supply products whose characteristics are defined and guaranteed by the notarized statement of an officer of the company is blacklisting if the product is found to be other than as specified.

HIDING QUALITIES

The tentative description for a one-coat hiding white or tint alkyd flat paint is as follows:

A "tint" shall be understood to be a white paint to which colors are added to produce light shades but in which reliance for hiding is placed primarily on the opacity of the prime pigments. A "color" shall be understood to be a paint wherein hiding is obtained by a combination of color particles and prime pigments. Color particles shall be similarly durable to prime pigments and show excellent resistance to alkali and fading. Color paints shall have the same characteristics as established for whites and tints except for formulation.

The product shall be a regularly manufactured product and be a standard item of the producer marketed for public purchase for not less than three years prior to date of bid. Any suitable blend of prime and extender pigments may be used provided the resultant product meets the characteristics required by this description, except that a rated value shall be established as described here. Awards may be made on that product which, in the opinion of the purchasing division and the advisory committee on paints and related products, *offers the best value.* The vehicle shall be a soya bean, glycerin or (penta) and phthalic anhydride alkyd resin in a solvent of the odorless petroleum type.

All containers shall be labeled, and the label shall contain a general analysis of the contents of the container to which applied. One such label, or certified copy thereof, for each paint shall be attached to the bid when presented, together with a statement specifying the type of each pigment.

The desirable characteristics for this type of paint are as follows:

Hiding units prime pigments	26
Vehicle nonvolatile by weight	28½%
Pigment vehicle concentration by weight	53%
Weight per gallon	——
Grind not less than	3
Stormer viscosity kreb units	85 ± 5
Overnight gloss 60° glossmeter	2–6
Time to dry hard	12 hours
Square feet covered per gallon	500
Thickness dry film approx.	.002 inch
Scrubability—No. of rubs (see test)	3600
Washability—No. of times (see test)	8

The manufacturer is required to enter opposite "hiding units prime pigments" the number of hiding units based upon the values of the prime pigments per gallon of paint using the Hallet System, as shown in the table of values below. The hiding

Applying paint with a roller is the most satisfactory technic because it is cleaner and less expensive than the brush and spray gun methods and needs only one coat.

Table of Values of Hiding Units, Hallet System

Basic carbonate white lead	1.00
Zinc oxide	1.35
Lithopone	1.79
High-strength lithopone	2.55
Titanated lithopone	2.53
Titanium barium (30%)	2.83
Titanium calcium (anatase)	2.90
Titanium calcium (rutile)	3.80
Titanium dioxide (anatase)	6.53
Titanium dioxide (rutile)	8.16
Titanox C	2.90
Titanox HTRC	3.80
Antimony oxide	2.33

value of any prime pigment used and not included in the list shall be furnished by the manufacturer except that any prime pigment used shall be one in general use in the formulation of commercial paints.

Having determined the weight of each pigment in the gallon of paint, multiply it by its hiding value in the foregoing scale. Add the results to get the total hiding units in the paint in accordance with the table. These should equal the figure entered by the manufacturer. If they do not, the material does not meet the requirements as will be discussed later.

Other characteristics being satisfactory, a relative value for each paint can be established by comparison of price and hiding units. The formula is

$$\frac{\text{Rated hiding value Paint A}}{\text{Rated hiding value Paint B}} = \frac{\text{Cost per gal. Paint A}}{X}$$

Example: Paint A has 26 hiding units, Hallet System, and costs $4.50 a gallon. Paint B has similar and satisfactory characteristics otherwise but has 20 hiding units. The comparative value then is $\frac{26}{20} = \frac{4.50}{X} = \$3.45$

Another method is to divide price into H.U. to get unit value per H.U.

Similarly, if Paint A has a warranty of eight washings and Paint B of only five, then on the basis of this characteristic Paint B is valued at ⅝ of $4.50 or $2.81. This might not be entirely accurate but is considered a definite indication of relative durability.

The price of a paint may or may not have any relation to its value. There are two divergent and conflicting interests in purchasing, that of the salesman whose job it is to sell his product and that of the user whose aim is to get a paint that will result in the lowest cost per year of use.

These are considered the important quantitative and qualitative characteristics of a flat alkyd paint which will meet the six-year standard previously described. A quick run-down on some of them goes something like this:

A properly formulated 26 hiding unit paint almost certainly will cover a new surface with one coat. It is certain to cover a previously painted surface of the same or similar color with one coat. It must be remembered that complete coverage is not enough. The resultant film must be substantial enough to take the anticipated use.

The relation of nonvolatile vehicle and pigment vehicle concentration on the order of 28½ to 53 per cent assures a well balanced paint of this type, certain to meet the qualitative requirements listed. The viscosity figure establishes the workability and stability of the wet film. The weight per gallon is needed to calculate the hiding units' value of the pigments listed in the general formulation. Drying time is important in establishing schedules and obtaining a relatively dust-free film.

Square footage indicates to the painter how far the material should go and give safe, durable coverage. On a properly prepared surface a lesser area indicates poor paint application. A substantially greater area indicates overthinning and a film thickness that cannot be expected to perform in accordance with established characteristics.

Dry film thickness is a check on those elements of formulation and manufacture that produce a film density associated with durability and smooth appearance of the finished surface. To crowd 26 hiding units of prime pigments into a dry film 2½ mils thick (.0025 inch) requires expensive pigments of a high order of hiding and thorough grinding to assure good dispersion and wetting of the pigments.

Washability is very important in this standard. The number of washings is at best a small figure and the increase or decrease in that figure is vital. The relative value of a paint that will take only five washings as compared with one that will take eight washings is the difference between having to paint corridors sometime during the third year as compared with the probable maintenance of a six-year standard, to be discussed later.

SPECIFICATIONS

Let us consider the matter of specifications. The committee decided early in its deliberations that these were of doubtful value when applied to paints and probably to most standard items. Too many people believe they provide the complete answer to getting what is wanted. As applied to standard items, they probably serve only to confuse the issue. In many cases they are either copies of information furnished by one manufacturer, in which case they are not competitive, or they are a combination of points selected by a specification writer. In the latter case, it is extremely doubtful whether they achieve the balance to be found in any one of several standard materials.

The progress in paints today is so rapid that by the time a specification is prepared, checked and published, it may be out of date. Unless the specification describes a paint that has been tested in commercial use for the time required, it is guesswork. Then there is always the question as to who is to see that the paint really is manufactured as specified and who pays for the inspection. If this cost is added to the price of the paint, where is the saving?

Another angle of specifications is frequently compromised—the tendency of the inspector or the purchasing agent to say, "Well, there are minor differences between the product and the specifications but they are near enough to each other so the product is acceptable." This, of course, negates the value of the specifications. Either a product meets or it does not meet the specifications. If the intent is to publish only a description, there is no justification in calling it a specification and no necessity to confuse the issue when more practical ways are available. There is no assurance in the paint field that the product of any two manufacturers using the same specification will produce the same result. In fact, all of them frankly state each has trade secrets that will not be found in any specification. These may mean the difference between satisfactory and unsatisfactory performance.

What the user wants is not a concoction but a dependable material which can be purchased in varying quantities at irregular intervals and which can be found on the shelves of a near-by distributor if a little more is needed to finish a job. The user wants a material which if it fails to perform as specified can be laid to definable reasons. Such a material can be selected with assurance from the standard products of a substantial number of reputable manufacturers.

Few, if any, reputable manufacturers will degrade standard products when supplying them on a bid. In a line as competitive as paints, it makes sense to use the results of millions of dollars spent in research, testing, manufacturing control, and reputation built into the standard products of well known, dependable manufacturers, especially when at best the saving in material can be only a fraction of a thousandth of a cent per square foot.

(To Be Continued Next Month)

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Lessons in Good Housekeeping

Basic Technics: Waxing

EMILY C. DEMING
Executive Housekeeper
Butterworth Hospital, Grand Rapids, Mich.

THIS sixth section of Miss Deming's lessons in housekeeping technics covers the proper method of waxing floors, and concludes the lectures on care of floors. In previous issues of the magazine, she has dealt with orientation to the housekeeping department, equipment, sweeping, mopping and machine scrubbing. Succeeding lectures in this series will encompass dusting, window washing and screen care, wall washing and spotting, readying the patient area, waste disposal, control of rodents and insects, safety, and special technics.—ED.

NOW we're going on to the final step in the care of floors, and that is the waxing. We have these additional pieces of equipment: an applicator, and for that we use one of our old worn down (and sometimes clipped off to a comfortable, even level) dust mops. We dampen it with hot water before we begin, and I mean just barely dampen it like this—feel it. There are all sorts of ways of putting wax on, there are fancy applicators, lamb's wool pads, and so on. We have found that this is quick and easy. We have plenty of them. We have our wax pan, and we have the wax.

The most expensive thing we buy is our wax. We buy a fine quality wax, and one that is fully approved by the Underwriters Laboratories so that we know that we have a nonskid surface. That is, our floors when they are waxed and buffed have a beautiful soft sheen and they're not a bit more slippery because of the wax than they would be if they were merely clean floors. Actually they might even be more slippery if they were dirty floors because there might be grease and wax accumulated on them on which people could slip. So when people say to us, "Oh, I'm afraid to walk on those floors, they shine so I know I'm going to fall!" You can always say, "Oh, no sir, these floors are safe because we use a wax that has a slip deterrent in it, and they're just as safe as floors can be made."

As I said, wax is an extremely expensive part of our equipment. We put in the pan only the amount that we think we're going to use. It is dispensed to your individual floor stations in one gallon containers. Now, if you have a little wax left in your pan put it in a small separate container. Never pour it back into the fresh wax jar. And above all things, if for any reason you still have some of the wax you have been using—and manage to slip into the storeroom when we aren't watching the keys properly—don't ever pour it back into the drum itself. Bacteria will grow in wax, and some well intentioned soul on occasion has stirred a wax drum with a stick he picked up because the wax didn't run freely enough, perhaps, in cold weather, or he has been economical and poured a few ounces of wax back into a gallon jar, and when we went to use it we found that the bacteria growth had ruined the wax. It happened to us once with a small drum of wax and I know of instances of which it has happened to other people. So we take out only the small amount of wax that we feel we're going to use. We can always pour a little more into the pan. It's much better to have to do that than to have to pour some back, and if you are very careful and think well about the amount of space you have to do, in a very few times you'll come within a few ounces of the exact amount of wax you're going to use. You know, the surprising thing about wax is how little it takes to do a good job. The thinner the coat, the cleaner the floor, the better the buffing, the better the final job.

Another point is, you don't want the wax to spill out on the floor and the wax pan is shallow. Your applicator is lightly dampened. You put it in the wax like this—gently, evenly. Don't just plop it in. You dip it so that the wax is distributed equally the whole length of the applicator. If you want to remove a little excess wax run the applicator over the end of your pan, like this. See? If you have too much wax on the applicator it's going to streak the floor and make it look uneven.

Now, I prefer a walking stroke about, oh, 10 to 12 feet, a little more or less depending on the amount of area that you have to do. But you go right straight along. If, that is, you're working in a hall. If you're working in an obstructed area make your strokes short, and make them even, perhaps just two or three feet in length depending on the amount

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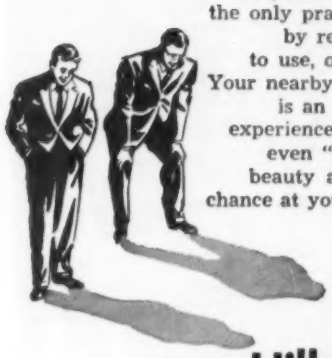

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of space you have. Let your strokes just barely come together. Don't overlap. In sweeping and dust mopping we always overlap. In waxing we do *not* overlap. It is most important that you remember this because you can get little streaks of slipperiness if you overwax on an overlap; because when the floor is buffed you don't remove the moisture content quite as thoroughly in these areas before they have entirely oxidized—and the first thing you know you have a little spot of slipperiness. So you just bring your strokes together. See? Like this. You start with practically no pressure at all, and you go the length of your stroke. If it's an area in which you can turn around and come back, walk the same distance. If you're going right up against a wall area you may come backward for the second stroke, coming down like this a short distance, and then swinging your body so that you are walking in the opposite direction for the second stroke. The third stroke would be put down walking toward the wall again. The fourth would be walking away from it, and so on. And always when working on the jaspé linoleum floors—work with the pattern.

Now usually you are going to get about two, possibly three, long strokes from one dipping. In your shorter strokes put much less wax on your applicator and dip it as you need to. As you have started with almost no pressure on the applicator, when you begin to notice that the film lightens come down with a little pressure until you see that the wax is gone. When you reapply your applicator you come down with what I call in so many of these operations a feathering stroke. You don't just plop down—bang! You slide into it again so that you don't have a lap line. What did you notice about the way I approached that baseboard? What did I do? All right, what didn't I do? I didn't wax quite up to the baseboard, did I? Is anybody going to walk along that area? Are they going to push stretchers or wheel chairs or any sort of traffic equipment along that area? No, they aren't, are they? And so if we put wax there we're just giving ourselves a removal job later on.

Notice this buffing brush. What are these bristles called? Right! A tampico bristle brush. You see the soft burnish of the wax on the bristles? All right. When it is buffed over the floors it will carry enough wax onto that area so that area gets all the finishing it needs to protect the surface of the floor, and since there is no traffic to wear it off it will last just as long as the center area where we are putting more wax.

There is one exception, I think, to the rule about leaving from 6 to 8 inches of free floor between the wax coat and the baseboard, and that is when we are putting a new soft floor in service for the first time. As a rule, I feel then that we should put one coat of wax all the way out. And of course, as you know when we are putting new areas in, we use extremely thin coats and we use three or four of them. If we have time enough, say a period of two days for a new floor, the oxidation is better, the floor has a chance to harden down and we buff out soft spots and have a beautiful burnished floor. As new areas go into service each of you will be given time to help ready both new hard and soft floors for use.

The waxes we use dry in approximately 20 to 30 minutes. Never run your brush over wet wax. Wait until it is dry. And I'm awfully sorry to

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NEW DU PONT SAFETY FLOOR WAX

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Plus beauty, protection and long wear

For offices, schools, hospitals, stores, restaurants and other public buildings Du Pont Safety Floor Wax is offering a new measure of anti-slip security. *And* it gives this vital added protection with no sacrifice in beauty, washability and extra-long life!

A premium slip-retardant wax, Du Pont Safety Floor Wax is suitable for linoleum, asphalt tile, rubber tile, vinyl tile or any other resilient floor covering. It's water-resistant—dries to a satin gloss in 20 minutes, buffs to a high shine. Can be damp-mopped and buffed again and again with no loss in anti-slip protection! Investigate Du Pont Safety Floor Wax today!

HERE'S WHY DU PONT SAFETY FLOOR WAX MAKES EVERY STEP SAFER! "Ludox," the amazing anti-slip ingredient in Du Pont Safety Floor Wax, is colloidal silica; tough, transparent particles of minute size. Under the pressure of a footstep, these particles are pushed into the larger, softer wax globules. This action absorbs much of the foot's forward-moving energy—gives positive traction underfoot!

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★ 30 GALLONS ★ 55 GALLONS

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For Industrial and Institutional Floor Maintenance

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For name of nearest source write Du Pont Co., Specialties Sales, Wilmington, Del.

tell you that when I say wait, I don't mean that you should twiddle your thumbs for 20 or 30 minutes.

Because of the amount of equipment involved we normally have finished a scrubbing operation of the floor before we start the waxing operation, simply to eliminate confusion and traffic hazard. What I do expect you to do in this period of waiting is to spot carefully any areas that may need it. Check, perhaps, for high dusting. Check for the dusting over the door ledges if you're in a patient occupant area. If you have had to remove furniture from the area, the time to clean it, buff it, and polish it is while you are waiting for the wax to dry so that when the floor is completed the furniture is clean and polished and ready to put back into place. And be sure to use the tri-dollies for moving all heavy pieces to avoid scuffing the fresh wax and be sure the dolly wheels are clean too!

Now, because the areas of flooring under heavy furniture, with the exception of desks where people are constantly moving their feet back and forth, are not trafficked we usually move back files, bookcases, heavy immovable furniture and put it in place before we put our next wax coat down; and then we're very careful to skirt these pieces of furniture with a 6 to 8 inch edge just as we did the mopboard in our first coat.

If there is time enough I like to allow 10 or 15 minutes between the application of the coats after we have finished the buffing operation. If you are pressed for time, when you have finished the first buffing then put your second coat of wax on exactly as you did the first and just as thinly. You follow exactly the same buffing procedure for the second coat that you did with the first, using the tampico brush and polishing very carefully. Now, after you have buffed it out there will be some highlights. I don't think you can put wax down without having a few. That is what the heavy burlap pad or the wool pad is for; depending on the type of floor and the finish, we put one of these pads on and run the machine over the floor rather quickly just to take out the highlights. That's just a little something extra to make it look as well as we possibly can.

To apply this pad we put it on the floor, lift the brush, center it exactly, lower it carefully, retract the wheels and away we go! We spend a greater amount of time buffing on a second coat than we do on the first coat. I believe that it is a safety factor and that when we dry that much moisture out of the floor finish we hasten the process of the hardening and finishing of the floor a little bit, get a little better finish in a little less time with a greater degree of safety. So I want you to buff the first coat quickly, the second coat, a little more slowly. Put your finishing pad over the floor and then we put all of our tools away for the day, and that is a careful, exacting job in itself.

Because of the skid resistance of these waxes you get a great deal of tracking—these track marks that you see through the building—the first couple of days. Now, what you should do is to re-buff within 24 hours and then re-buff again each day for the first two or three days after you have done an area. Then, because of the pressure on our machines, you have to be content with every other day, as a rule, because there just isn't enough machine time to go over every floor every day. And it isn't just *getting* the floor waxed that's im-

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Little things mean a lot when you're sick. A tray covered with a clean attractive cloth, for instance, can perk up a patient. Make him appreciate the food that's been so carefully prepared. Maybe eat more of it—and get stronger faster.

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AND SHOWS WHERE IT COUNTS

Simtex Mills

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portant. It's *maintaining* that coat of wax after it has been put down. It's very careless to spend as much time as is involved in stripping and waxing and then let the floor deteriorate for lack of proper buffing and maintenance. If you have spillage that necessitates a complete scrubbing of a small area, that area can be hand-waxed, and the next time you buff the floor the buffing will carry it so that the patch won't be visible.

If there is wear in the traffic lanes, for instance, those leading to the elevators or entrance-ways which wear down so quickly in spite of our most careful maintenance, those areas may be cleaned. Usually they should be dry cleaned with a steel wool pad after they have been carefully mopped, gone over with a dust mop after they've been steel wooled, and then rewaxed in the traffic lanes and buffed in exactly the cycle of operations that we use when we're doing it from scratch. This method will let us carry our floor for sometimes a few days and sometimes a few weeks longer than if we had let the worn areas become more worn and show up so that it made the whole floor look untidy and unpleasant.

A great deal of time is involved in these two operations. It takes about three and a half to four hours of manpower to strip a thousand square feet of floor and it takes from two and a half to three man-hours to wax and buff a thousand square feet of floor. And a thousand square feet is only a little bit of floor when you think how much there is in this hospital! Therefore, work carefully, conserve well, protect by planned buffing, careful patching, early recognition of the signs of wear in the traffic lanes so that we retread those and keep our floors looking well as long as possible on one strip-waxing operation.

This is a lot of material for you to have absorbed. We're going to have a general review before we go on to any more work, because I think it's extremely important that each one of you knows exactly how these machines operate, how they are cared for, how they are cleaned when they are taken back to the workroom, how they are used on the floors, how important it is to have your wet markers out when you're doing large areas of the floors, how careful you must be of your cables, of leaving any equipment near a door, a corridor corner, entrance hall or any place where people may walk without thinking—not see it and be injured because it was in the wrong place.

Actually, the floors have looked much better in the last month or so as we have worked with you individually. I think the new men each have had a little time to work on daily buffing; most of you have not done an actual scrubbing operation, and you will have an older man with you the first time you do it. Then as you develop skill you will be able to go on and take care of your own floor areas entirely by yourselves. It will be nice to see whose floor can look the best, let's say, for the next month.

And don't forget that I'd like your notebooks to carry an illustration of each kind of equipment that we have shown here in class today. That's right—each piece of equipment: wax applicators and all the rest. Let's see how much ingenuity you can show in finding sources from which to clip them or you can draw them if you're really skillful. You ought to be able to draw as well in your notebooks as I can on the blackboard, you know!

Photograph features "Lifetime" Vinyl Tile made of BAKELITE Vinyl Resins by **Robbins Floor Products, Inc.**, Tuscumbia, Ala.

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It is flooring made of BAKELITE Brand Vinyl Resins. It is lustrous and rich in bright color. And five, ten and more years from now it can still be just as beautiful. That's because time and traffic do not take their toll with this type of flooring.

The impervious nature of flooring made of BAKELITE Vinyl Resins is superior protection for your clients, and for you. By specifying, you assure clients a broad selection from a full range of colors and patterns. You assure superior advantages in use—wear, chemicals, scuffs, stains soil and cleansers are resisted years longer. You specify flooring that cleans easier and makes maintenance costs lower.

These are welcome advantages for *any* kind of building . . . benefits that are simple to attain by specifying "flooring made of BAKELITE Vinyl Resins."

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WESTBERG—

(*Continued From Page 82*)

When the doctors found something which required me to stay in bed for three weeks, I was compelled by my loneliness to look inside myself as I hadn't looked for 30 years. What I found didn't please me. So I was glad that a very understanding nurse introduced me to the chaplain with whom I talked about many things. When I left the hospital, I felt particularly indebted to this new kind of service which hospitals are rendering."

She talked to him in a manner which chaplains describe as "patient-centered" as contrasted with "nurse-centered" conversations. She was willing to deal with his feelings and made it easy for him to tell her exactly how he felt about a number of irritating problems. There is nothing new about this way of conversing because most people who have a knack of helping other people use it instinctively. The "new" part of it is that we have finally tracked down *why* such people have been so helpful and so we have developed a theory around its basic principles. Having discovered the essential ingredients of worth-while conversations, chaplains are attempting to describe these to students of nursing. It is our hope that through such conversations they can then be of real help to patients who are trying to think through difficult problems which are confronting them and are interfering with medical treatment.

During the last 10 years a number of hospital chaplains have analyzed hundreds of conversations which nurses have had with patients. This was done by asking nurses to write down in detail portions of significant conversations which they had on a particular day. It was interesting to note that the average conversation centered more around the nurse than the patient.

In a typical case study we saw a patient who was trying to express a pent-up emotion that was tearing him apart inside. He believed the nurse to be the kind of person he could trust and who could be helpful to him. Now he had mustered up enough courage to talk to her about his deeper anxieties. But as he began tentatively to tell her significant things to see whether the nurse would accept them, and him, without realizing it she replied in a "preachy" manner, giving the impression that it was "wrong" for him to have such negative thoughts. The patient then listened obediently until she finished. Then he tried again to see if maybe she would be willing to try to understand the *particular* nature of the predicament he was in. But this time what he said reminded the nurse of somebody else "who had the same problem" and she took over the conversation again. Dismayed and hurt he gave up trying to talk about himself and bottled up his fears and worries again. But bottling them up did not solve the problem for they continued to plague him and make medical treatment difficult.

The busyness of the modern hospital presents one very real obstacle to the healing process. If the illness of the particular patient is in any way related to his inner feelings the hospital setting does not offer the best opportunity for him to pour out his heart to someone who cares in an unhurried and natural way. In our attempt to make our hospitals efficient (which they have to be) they have become so businesslike that cold routine often replaces warm concern. Yet the nurse is the one bright spot in the picture. This is not an idealistic statement, for daily in one of the busiest hospitals in the country I see nurses who *do* find time to get close to their patients. Frequently I hear a patient say, "Thank goodness there is a wonderful nurse who has taken time to come in and talk to me every day. She has helped me more than she will ever know."

We believe that the nurse is in a more strategic position to help patients with inner worries and anxieties than anyone else on the healing team. Intuitively she seems to know how to be at the patient's side at just the right time. If, in addition, she is equipped to talk with the patient in the right way at the right time, then the value of nursing care takes on a dimension that contributes immeasurably to the healing process. The hospital chaplain who has learned to help people through the careful use of words is anxious to share with nurses some of the insights he has gained. He is convinced that the intellectually mature nurse is his natural ally in the fight against debilitating fears and anxieties which block the flow of God's healing power.

WHY CRANE DURACLAY IN LARGE HOSPITAL

New Mazel House Addition to Chicago's Edgewater Hospital specifies CRANE

Large hospital plumbing fixtures are frequently subject to severe thermal shock while in use. The result is crazing and cracking of the fixture . . . and a need for replacement long before it has given its money's worth in service.

But that doesn't happen when you have Crane fixtures.

Because large Crane hospital fixtures are made of Duraclay—a special vitreous glazed earthenware developed in the Crane laboratories.

Mazel House Addition, Edgewater Hospital, Chicago, Illinois. Architect: Edward P. Steinberg. General Contractor: Gust K. Newberg Construction Co. Plumbing Contractor: World Plumbing Company.

Crane Mayo surgeons scrub-up sink of Duraclay, permits surgeon to scrub to shoulder without touching non-sterile parts of fixture. Dial-ese foot pedal mixing valve for hot or cold water, or mixed flow.

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IS A MUST FIXTURES

Duraclay is unaffected by thermal shock and is impervious to acids and stains that affect ordinary hospital fixtures.

Crane offers a complete line of hospital fixtures, all designed in cooperation with hospital authorities for specific hospital use. All are equipped with famous Dialese controls.

Why not talk to your architect about the complete line of Crane hospital fixtures before you build, remodel or replace?

Crane Yale wash-up sink of Duraclay with foot pedal mixing valve which may be elevated to clean the floor. At left of picture, is pre-natal shower with thermostatic control valve and dial thermometer volume control. Hose and shampoo attachment. Vacuum breaker safeguards sterile water supply.

Patient's bathroom with Crane Whirlton siphon jet closet with integral bedpan lugs. Crane bedpan cleansing fixture, Neuday porcelain enamel bath, and Norwich vitreous china lavatory.

Crane pre-natal bath of Duraclay. Cut-out sides for ease of access. Thermostatically controlled water supply. Vacuum breaker safeguards sterile water supply against siphonage. Deviator spout for diverting water to spray.

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NEWS DIGEST

A.C.S. Report on Pooled Liquid Plasma . . . Hepatitis Cases Tripled . . . Ohio Association Marks 40th Year . . . Savannah Court Upholds 14 Defendants in Suit Over Dismissal . . . Joint Commission Issues New List of Accredited Hospitals

A.C.S. Report Shows Pooled Liquid Plasma Safe After Six Months at Room Temperature

CHICAGO.—Pooled liquid blood plasma stored at room temperature for six months or longer is fully as safe as whole blood so far as transmission of serum hepatitis is concerned, the board of regents of the American College of Surgeons declared last month in an effort to encourage use of plasma where other fluids do not serve the same purpose equally well or better.

Nevertheless, reintroduction of plasma therapy will not be achieved rapidly or without opposition, Dr. J. Garrott Allen, chairman of the college committee on blood transfusions and derivatives, said in an article appearing in the journal *Surgery, Gynecology and Obstetrics.*

Reviewing data on the preparation and storage of plasma under various conditions, and the subsequent incidence of serum hepatitis, Dr. Allen reported that among 300,000 patients receiving transfusions of plasma stored for six months at room temperatures, "not one case of hepatitis was reported." The statistical expectation on the basis of dried or frozen plasma would have called for 30,000 or more cases in this group, Dr. Allen said.

"The National Research Council and the National Institutes of Health have been reluctant to accept some of the above data or to approve the safety of six month old liquid plasma, which they must do if the physician is to be reassured or the manufacturer encouraged in plasma production," Dr. Allen declared. "The early reluctance of both these bodies is sympathetically understood. Their continued position on this problem after more than five years, however, is not. The clinical data on which the safety of pooled liquid plasma rests involves patients on whom follow-up ranged from six months to 12 years.

"There will always remain a small group of plasma recipients who develop coincidental infectious hepatitis during the period when serum hepatitis might occur," the article in *Surgery, Gynecology and Obstetrics* continued. "Whenever this event casts suspicion on pooled plasma, the remainder of the units from the pool under question should be traced to determine whether or not multiple cases of hepatitis have occurred. If two or more cases turn up among recipients of plasma derived from the same pool, the diagnosis of serum hepatitis is almost a certainty. If only one case occurs and none appears among the

(*Continued on Page* 148)

Speakers Praise Blue Cross on Anniversary

CHICAGO.—Commercial insurance companies were afraid to enter the field of health and hospitalization until Blue Cross showed the way, Dr. Frank R. Bradley, president of the American Hospital Association, said here last month.

"Now that Blue Cross has pioneered successfully, the insurance companies want to muscle in," he added.

Dr. Bradley spoke at the 25th anniversary dinner of Blue Cross, held here in conjunction with the annual conference of Blue Cross and Blue Shield plans. The dinner was attended by more than 600 plan representatives and board members attending the conference.

Other speakers were Abraham Oseroff, chairman of the Blue Cross commission, Dr. L. Howard Schriver, president of the Blue Shield commission, and Gardner Cowles, publisher of the Des Moines, Ia., *Register* and *Tribune* and editor of *Look* magazine. Noting that "any idea which lasts 25 years and attracts 47 million people is obviously a sound one," Mr. Cowles predicted the greatest period of growth for Blue Cross lies in the next 10 years because it offers "the best possible program of hospital and medical prepayment at reasonable cost."

Hepatitis Cases Tripled in Three Years, Vital Statistics Report Reveals

WASHINGTON, D.C.—The incidence of hepatitis in the United States has tripled in the last three years, the National Office of Vital Statistics reported here last month. Hepatitis is now in fifth place among communicable diseases, the report said.

Dr. C. C. Dauer, medical adviser in the vital statistics department, said 49,722 cases of hepatitis were reported in 1954, an increase of 50 per cent over the incidence during the previous year. The 1953 incidence was 93 per cent higher than 1952, Dr. Dauer added.

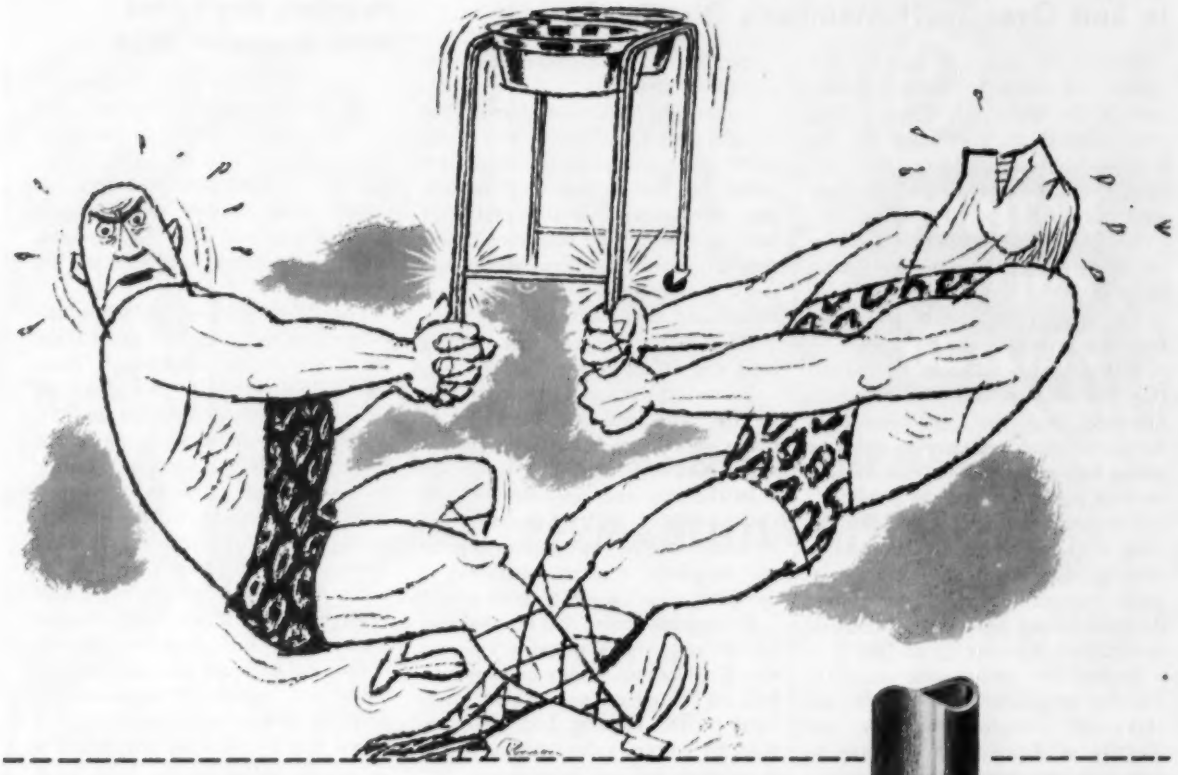
The disease occurs more frequently among school children than among adults, but hits adults harder, the report indicated. Usually, Dr. Dauer said, it takes adults six weeks to two months to recover, while children normally recover in two or three weeks.

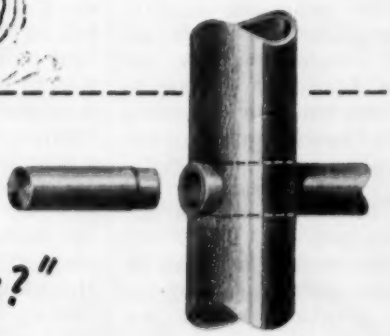
The mortality rate from hepatitis was described as "very low," but it increases sharply among babies and persons over 50 years old. The death rate may run as high as 25 per cent among elderly persons, the report said.

Hepatitis is "one of the more baffling" of the communicable diseases, Dr. Dauer stated. "Apparently it is spread by person-to-person contact but no one knows exactly how it is transmitted," it was reported. Antibiotics are ineffective in hepatitis; the only treatment is rest and high protein diet, Dr. Dauer said. Gamma globulin is effective in controlling outbreaks of the disease and has been used to inoculate contacts and families of hepatitis victims, he added.

Tri-State Schedules Its 25th Assembly

CHICAGO.—The Tri-State Hospital Assembly, sponsored by the state hospital associations of Illinois, Indiana, Wisconsin and Michigan, will hold its silver anniversary meeting here May 2 to 5.





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Savannah Court Upholds Defendants in Suit Over Staff Member's Dismissal

SAVANNAH, GA.—A doctor's suit against 14 members of the medical staff of the Warren A. Candler Hospital resulted in victory for the defendants and the hospital here last month, following a sensational four-week jury trial.

Dr. Paul Nelson Fleming, the plaintiff, had sued each of the defendants for $500,000, charging they had conspired illegally to have him dropped from the hospital staff.

The defendant doctors maintained they had recommended Dr. Fleming's dismissal from the staff because of malpractice and misbehavior, and were acting for the good of the hospital, the medical profession and the public.

The jury found for the defendant in each of 12 separate $500,000 suits; suits against two of the doctors originally named as defendants were dropped during the course of the trial in Chatham Superior Court here.

During the month-long trial, Dr. Fleming sought to prove the defendants had conspired willfully and illegally to deprive him of hospital privileges and, hence, his professional livelihood. Plaintiff's attorney introduced as witnesses a number of Dr. Fleming's former patients, who said they were satisfied with the care they had received.

Defendants' attorneys contended Dr. Fleming was performing many unnecessary operations, that he was incompetent to do some of the surgery he undertook, grossly failed to diagnose many of his cases, and was a heavy drinker. Defendants' motive was not to deprive Dr. Fleming of his medical license but to protect the public and the hospital, it was alleged.

Among the witnesses for the defense were many of Dr. Fleming's former patients whose ailments were allegedly misdiagnosed or mistreated.

Summing up the testimony for the defense at the conclusion of the trial, Alex A. Lawrence, defense counsel, said Dr. Fleming was "scalpel happy" and "not content outside an operating room." Far from engaging in an illegal conspiracy, Mr. Lawrence said, the defendant doctors were performing a public duty. "This is a vastly important case, not only to the medical fraternity here but to the public as well," he stated. "If they are sued for $500,000 every time they get rid of an evil element in their midst, what doctors are going to try to keep the profession clean?"

Earlier, the defendant doctors had charged that Dr. Fleming was doing numerous fenestration operations for which he was inadequately trained, that he removed nasal septums of patients who needed only medication, and that on several occasions he had failed to diagnose cases of cancer, brain tumor and other serious conditions.

"Unnecessary surgery was the big evil," the defense contended.

Following the jury's verdict finding for the defendants, Dr. Fleming's attorney announced immediately that an appeal would be filed.

In charging the defendant hospital staff members with conspiracy, Dr. Fleming claimed his membership on the hospital's courtesy staff was a "property right" worth $50,000 a year.

Defendants denied that hospital staff membership was a property right or that Dr. Fleming, or any other doctor, had any vested interest in staff membership. Dr. Fleming had agreed to abide by hospital rules when he signed application for staff membership, Mr. Lawrence pointed out. "This was not a right, but a privilege," he declared.

Defendants acknowledged the hospital may have been lax in accepting Dr. Fleming's application in the first place. "Obviously had the Candler Hospital made an investigation of Dr. Fleming, it would not have accepted him," the attorney stated.

During the trial, it was brought out that Dr. Fleming had practiced surgery at the Candler Hospital for several years before the doctors there took action against him. The decision to act was brought about by his failure to diagnose a brain tumor in a child who had been under his care for several months, it was reported. When it became evident the medical society was not going to act against Dr. Fleming, Mr. Lawrence said, the defendant doctors met and decided it was their "solemn duty" to bring the matter before the Candler Hospital board of trustees. Defendants conducted a careful investigation of Dr. Fleming's cases before proceeding, he said, but by-laws of the Candler Hospital did not call for any hearing on the evidence.

Mr. Lawrence said the doctors should be praised, not penalized, "for trying to rid this community of an evil."

Joint Commission Lists Hospitals Accredited as of December 1954

CHICAGO. — The Joint Commission on Accreditation of Hospitals has listed 3513 hospitals as fully or provisionally accredited as of Dec. 31, 1954, according to a bulletin published here last month. The number accredited the previous year was 3418, Dr. Kenneth B. Babcock, commission director, reported.

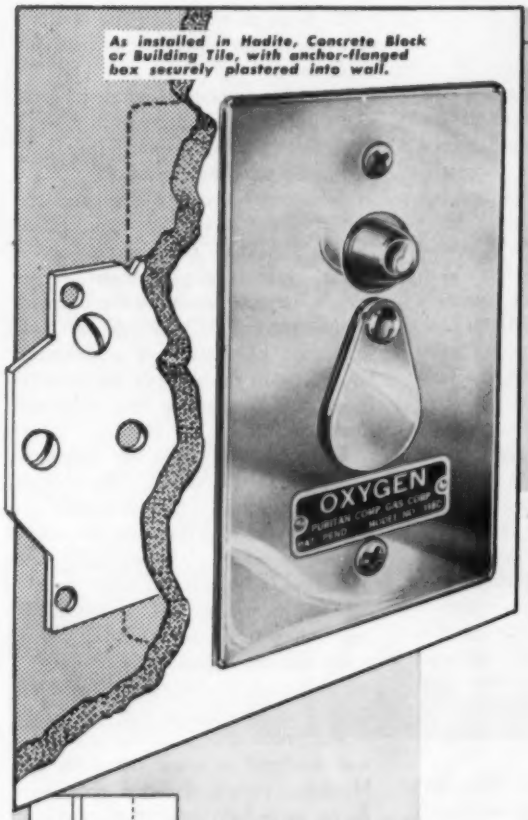
The 1954 list shows 2928 hospitals fully accredited, compared to 2920 the previous year, the bulletin said. There are 585 hospitals with provisional accreditation, compared to 498 in 1953.

"The list includes all hospitals surveyed by the Joint Commission during the last two years plus any carryovers from the American College of Surgeons which have not as yet been surveyed by our group," Dr. Babcock said. "At the close of 1954, there were 1295 hospitals which were overdue for a survey. Of this number 296 were provisional accreditations and 300 were either new requests or nonaccredited hospitals requesting resurvey. It is hoped that by 1956 all hospitals will have been visited by the Joint Commission's surveyors."

Surveys conducted in 1954 included 1385 hospitals, Dr. Babcock said. Of these, the largest number were conducted by field representatives of the American Hospital Association, who visited 617 hospitals. Visits were conducted by surveyors for the other organizations, as follows: American Medical Association, 324; American College of Surgeons, 256; Canadian Medical Association, 84; American College of Physicians, 54; American Psychiatric Association, 40, and the Joint Commission staff, 10.

The qualification for accreditation that stipulated a hospital must be registered with the American Medical Association has been revised since the A.M.A. discontinued its hospital registry, Dr. Babcock said. The commission now requires that U.S. hospitals must be listed in the *Administrator's Guide* issue of the American Hospital Association journal instead, he explained.

Dr. Babcock announced three new members of the board of commissioners: Dr. Warren H. Cole, Dr. Frank R. Bradley, and the Rt. Rev. Msgr. Donald A. McGowan. Retiring commissioners were: Dr. Arthur W. Allen, Dr. Anthony J. J. Rourke, and the Rt. Rev. Msgr. John W. Barrett.



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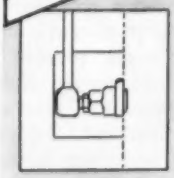

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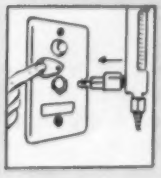

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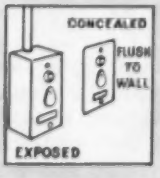

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40th Meeting of Ohio Hospital Group Stresses "Management for Progress"

CINCINNATI.—The auxiliaries ate the housekeepers' pork chops during one of the luncheon meetings, owing to a waiter's inability to distinguish between veal and pork, but otherwise nothing of an untoward nature marred the 40th annual meeting of the Ohio Hospital Association here March 7 to 10.

Henry N. Hooper, administrator of Cincinnati General Hospital, turned the president's gavel over to Jay W. Collins, administrator, Euclid-Glenville Hospital, Euclid, who will hold office for the 1955-56 season. Mr. Collins will be succeeded by Louis C. Rittmeyer, Dunham Hospital, Cincinnati, who was named president-elect during the meeting. Other new officers named included: first vice president, George Byrum, Ohio Valley Hospital, Steubenville, and second vice president, Sister Mary Aquin, St. Rita's Hospital, Lima. Lee S. Lanpher, Lutheran Hospital, Cleveland, was reelected treasurer.

The theme, "Management for Progress," was examined microscopically by assorted industrialists, university professors, and hospital people, the last usually bringing up the rear of the daily sessions with discussions designed to show how and whether industrial theories can be applied to hospital practice.

The opening session on Tuesday morning brought to the platform William T. Blomquist, assistant professor of industrial management, Miami University; Harry M. Hopkins, vice president in charge of operations, the Tool Steel Gear & Pinion Company, Cincinnati, and D. A. Endres, superintendent, Youngstown Hospital, Youngstown. Both Mr. Blomquist and Mr. Hopkins discussed the much-discussed problem of training and developing supervisory personnel. The audience was rather obviously pleased when the two speakers flatly contradicted each other in regard to the question of the number of people a supervisor should supervise. Mr. Blomquist, who opened the meeting, explained that a supervisor's ability to accept responsibility was contingent on four things:

"1. Unity of command. (He can't take orders from more than one boss.)

"2. Span of control. (The number of workers one supervisor can handle is limited.)

"3. Homogeneous assignment. (Assign duties of a similar nature.)

"4. Delegation of responsibility must be accompanied by authority."

"What we expect of a supervisory person," Mr. Blomquist summarized, "is that he shall be a leader not a driver; he shall take an analytical approach; he shall integrate the interests of the two groups (management and workers); he shall have a thorough knowledge of the skills of his subordinates, and he shall be able to accept responsibility."

When his turn came, Mr. Hopkins, diffidently but definitely, differed with Mr. Blomquist. "The theoretical approach of limiting the span of control is dead wrong and impractical," said Mr. Hopkins. "The supervisor cannot develop the practice of decision-making unless the span of control is so wide that the supervisor cannot oversee the work of his subordinates too closely."

The problem of motivating workers was analyzed in some detail by Mr. Hopkins. People do what they want to do to satisfy their own needs, he stated, those needs being primarily (1) the need for self-approval, (2) the need for the approval of others, (3) the need for security, and (4) the need to feel part of something larger than oneself. "What has this to do with the supervisor?" Mr. Hopkins asked—and answered: "It is possible to integrate the goals of the individual with the objectives of the organization, but only if the individual can see that he is satisfying his own needs as he sees them."

The subject of motivation came up again at the Wednesday morning session. George J. Dudycha, professor of psychology, Wittenberg College, Springfield, Ohio, defined the word bluntly as "getting the action we desire in others." "When we motivate another person," he elaborated, "we release his energy in a direction that accomplishes through him that which we want accomplished. I hasten to point out that motivation differs from command. When we get action by command, we do so by force, sometimes with an implied threat; when we get action by motivation, we do so somewhat shrewdly and with some sagacity and sublety." To motivate a person, he explained, that is, to secure the desired action, one must make the

Two lead brick size 2" x 4" x 8" – one cast in an open mold (right), the other extruded through a die in a hydraulic press (left)—were sawed in half lengthwise, to show internal structure. After planing and buffing, the halves were photographed. The photos were retouched to kill highlights and achieve uniform tone on both brick. The sink and shrink-hole were not touched.

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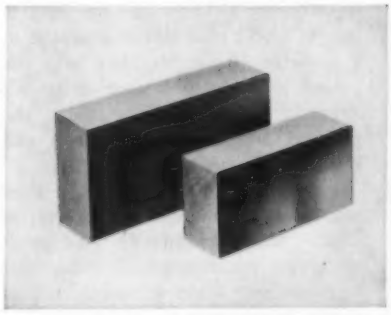

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person feel secure. Democratic approaches to achieving this goal, according to Prof. Dudycha, include the following:

"Share your responsibility. Take the attitude 'We have a job to do rather than I have a job for you to do.'

"Share plans and purposes.

"Be sensitive to workers' thinking.

"Praise. Use it generously. Look for the good things. Be honest in your comments.

"Give public recognition."

Honesty in dealing with employes was highly recommended by Mr. Hopkins, too, in the panel discussion held on Tuesday afternoon to summarize the morning's speeches. In answer to a question from the audience regarding the use of democratic methods in enlisting employes' cooperation, Mr. Hopkins stated: "If you are using democracy as a technic—*don't*. Technic always shows and the first time it shows—you're dead! Do it honestly or not at all. If you tell employes they are going to make the decision, let them really make it. If you are going to make the decision but want the benefit of the employes' thinking, say so. If your decision is vital and has to be made at once, go ahead and make it—and tell them to jump to it."

The Tuesday afternoon panel discussion, scheduled under the title "The Theory Is Fine, But—," indicated that hospital people are still finding it difficult to digest all of the pronunciamentos on efficient management handed down by industry and higher education, or maybe they are just tired of being told how stupid they are. Said Mary C. Schabinger, administrator of Detwiler Memorial Hospital, Wauseon, "Mr. Hopkins says that we must get somebody who is trained to do analysis and evaluation of jobs, but where in my budget am I going to put anybody like that?"

Mr. Hopkins grinned amiably and allowed that there was one subject on which all managers agree and that is: "It may be all right for you but it won't work for us."

In a session devoted to "The Nurse and Human Relations" on Wednesday afternoon, Sister Mary Isidore, R.S.M., director of nursing service, Mercy Hospital, Hamilton, Ohio, pointed out that it is important for nurses to be proficient in human relations because the nurse, "as the key person in the nursing team, influences others in the development of the attitudes involved in patient care. . . . If we can assist him to recognize sickness and suffering as part of God's plan and to accept it in a Christian spirit, we will help the patient attain mental peace and moral strength that will complement the physical care which he receives and thus aid his recovery."

Sister Isidore also offered a kind word for visitors (some of them, at least) when she stated: "We must recognize the therapeutic value that visitors have upon patients. A particular friend stopping to see a patient may do much more for an individual's recovery than medicines."

Ten affiliated organizations held concurrent meetings during the Ohio convention. They included the Women's Hospital Auxiliaries and the executive housekeepers (heretofore mentioned), the Ohio Association of Blue Cross Plans, Ohio Association of Nurse Anesthetists, Ohio Tuberculosis Hospital Association, Ohio Society of Hospital Pharmacists, Ohio Association of Medical Record Librarians, Ohio chapter of the American Association of Hospital Accountants, alumni of Northwestern and Washington University schools of hospital administration.

A.C.S. Report on Plasma

(*Continued From Page* 140)

remaining recipients, the diagnosis of co-existing infectious hepatitis is likely. The action of the board of regents of the American College of Surgeons was taken to encourage the national bodies concerned with the blood program to review the facts and, if found as stated, to approve once again the use of liquid plasma and thereby to achieve once again the improvement in patient care it affords."

Reviewing experience at the University of Chicago Clinics, where he is professor of surgery, Dr. Allen said the university was using plasma liberally at the time the American Red Cross discontinued distribution of dried plasma in 1952 because of the occurrence of serum hepatitis.

In contrast to other users, the university was experiencing no incidence of viral hepatitis, Dr. Allen said in an interview. "The university found it had not been using dried plasma supplied by the Red Cross, but was using its own supply of liquid plasma stored at room temperature for six months or longer," he explained.

Noticing the difference between their experience and that of other medical centers, Dr. Allen related, he enlisted the cooperation of the American Association of Blood Banks and sent questionnaires to hospitals reporting the total of 300,000 transfusions using pooled plasma stored at room temperature. The result of this study is extremely important in terms of patient care because of the advantages of plasma over substitutes, chiefly its value in protein nutrition, Dr. Allen explained.

6379 Interns Assigned to 850 Hospitals, Intern Matching Program Shows

CHICAGO.—A total of 6379 interns have been assigned to 850 hospitals in the 1955 interns' sweepstakes, it was reported here last month.

The National Intern Matching Program reported that this year's class was substantially larger than the 1953 group, which totaled 6051.

Seventy-six per cent of the students were placed in the hospitals of their choice, it was reported, compared to 82 per cent last year. The lower percentage means the plan is working better, an official explained.

"It means the medical students are using the program, as they are urged to do, listing all the hospitals of their choice, without regard for what they feel their chances may be. This means the plan is working the way it should."

The National Intern Matching Program, now in its fourth year, was organized by the American Hospital Association, American Medical Association, Association of American Medical Colleges, Catholic Hospital Association, American Protestant Hospital Association, and representatives of the student group.

Methodist Institutions Increase Service

CHICAGO. — Methodist hospitals estimate that they will serve a total of 1,133,453 patients in the coming year. Last year 1,176,461 patients were cared for by Methodist hospitals, the annual report of the Board of Hospitals and Homes of the Methodist Church states.

New buildings planned for the coming year will bring the number of church hospitals to 73 and homes for the aged to 69. The Methodist Church also provides 42 homes for children, 8 for youth, and 7 special agencies.

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New York Court Upholds Hospital in Suit Over Effects of Transfusion

NEW YORK.—Liability should not be imposed on a hospital for injury that results from a course of treatment adopted where no negligence or fault is present, the New York Court of Appeals held in an opinion reported here last month in the *Forum* of the New York State Hospital Association.

In the case of Perlmutter *vs.* the Beth David Hospital, the plaintiff brought an action against the hospital when she contracted viral hepatitis after receiving a blood transfusion for which the hospital charged $60, it was reported.

"Evidently persuaded of the difficulties besetting a plaintiff in recovering in a negligence action against a hospital under the rules of immunity applicable where injuries arise out of the care and treatment of a patient, her complaint contained no allegation of negligence," Emanuel Hayt, association counsel, said in the *Forum* report. Instead, the complaint sought recovery under the Personal Property Law, on the ground that supplying blood constituted a sale, with the implied warranty that the blood was reasonably fit for the purpose for which it was required.

The court of appeals held the transaction was not a sale under the law, and dismissed the complaint.

Pointing out the impossibility of detecting viral hepatitis in a donor's blood, the court indicated that if this transaction were classified as a sale within the law "it would mean that the hospital, no matter how careful, no matter that the disease producing potential in the blood could not possibly be discovered, would be held responsible if anything were to happen to the patient as a result of bad blood."

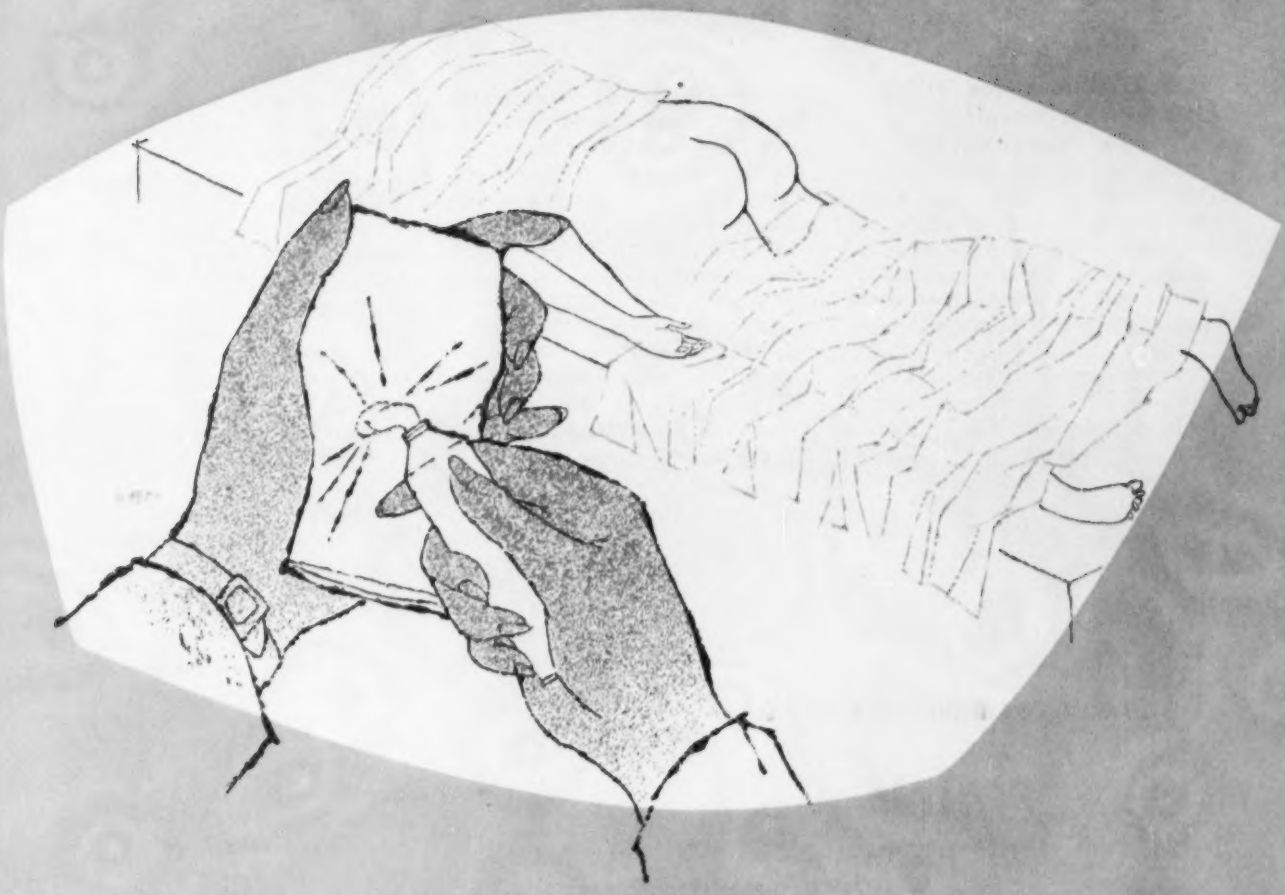
A ruling for the plaintiff would mean that the hospital would be liable irrespective of negligence or other fault, the court pointed out. "The art of healing frequently calls for a balancing of risks and dangers to a patient," the decision said. "Consequently, if injury results from the course adopted where no negligence or fault is present, liability should not be imposed upon the institution or agency actually seeking to save or otherwise assist the patient."

Columbia University Combines Two Schools

NEW YORK. — As a part of Columbia University's plan to broaden its teaching and research programs in the field of public health, the school of administrative medicine will be incorporated into the school of public health on June 30, it has been announced. The combined schools will be known as the school of public health and administrative medicine.

The merger results from "the fact that, increasingly in the future, public health administration will include the administration of medical care plans, prepayment hospital and medical insurance, and hospital administration," explained Dr. Willard C. Rappleye, dean of the faculty of medicine at Columbia.

Dr. Ray E. Trussell, who has been clinical professor of preventive medicine at New York University-Bellevue Medical Center since 1951, has been appointed executive officer of the new school. Dr. Trussell received his medical degree from the State University of Iowa in 1941 and was a Rockefeller Foundation fellow at Johns Hopkins School of Public Health. He is a founding director of the Hunterdon Medical Center, Flemington, N.J.



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2. White, C. J., A New Anesthetic for Certain Diseases of the Skin, J. Lancet, 74:98, March, 1954.
3. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.
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A.M.A. Committee Visits Osteopathic Hospitals to Study Education Plan

CHICAGO.—An American Medical Association committee has visited three osteopathic medical colleges and associated osteopathic hospitals to determine the quality of medical education provided in these schools, it was reported at A.M.A. headquarters here last month.

The committee's visits are being carried out in accordance with instructions from the association's house of delegates, it was explained. The committee, headed by Past President John W. Cline of San Francisco, hopes to make a report to the board of trustees and house of delegates prior to the A.M.A. meeting in Atlantic City next June, the report said.

The committee had visited osteopathic medical colleges at Los Angeles, Des Moines, Iowa, and Chicago, and associated hospitals at Columbus, Ohio, and Detroit and Flint, Mich., it was reported, and additional visits had been scheduled for the osteopathic schools at Kansas City and Kirksville, Mo., where the first such school was founded.

"In every instance, members of the committee were shown every kindness and the administrative heads of the osteopathic schools were most cooperative," Dr. Cline said.

Purpose of these visits is to determine the nature, scope and quality of medical education provided in the osteopathic schools, an A.M.A. release stated. The visits resulted from an action of the A.M.A. house of delegates in 1952, when Dr. Cline's committee on relations between osteopathy and medicine was established.

Chicago's Passavant Will Get $3 Million Addition

CHICAGO. — Passavant Memorial Hospital here has announced plans for the building of a large addition and for extensive remodeling of the existing hospital. Construction of the $3 million project will start in November, according to Edison Dick, president of the hospital board.

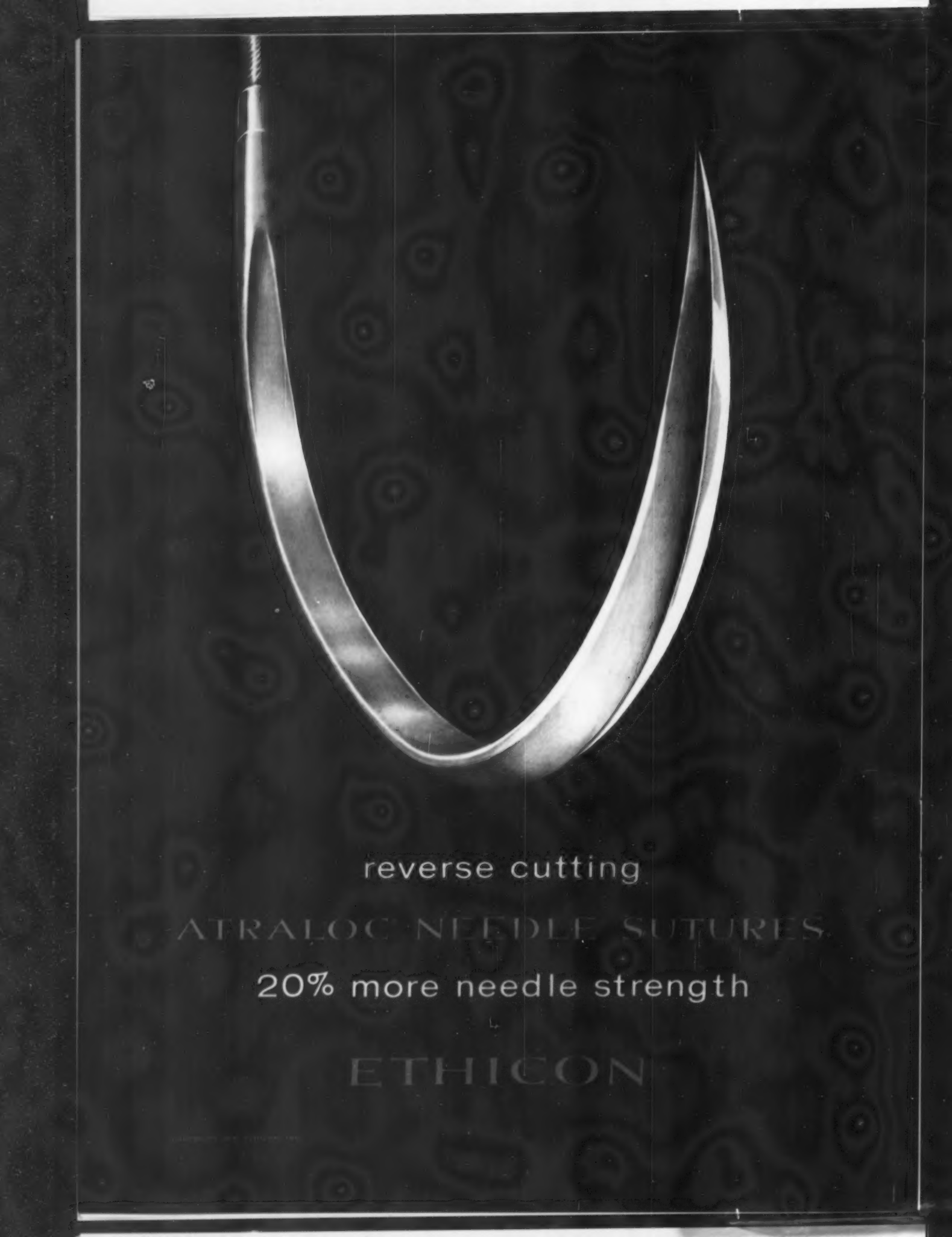
Additions include a four-story section to be added to the front of the present building and a 10 story wing to be added to the east side. The wing will add 85 beds to the hospital's 263 bed capacity. Surgical and postoperative recovery rooms will be located in the new wing. X-ray and laboratory departments and a blood bank will also be lodged there. Supporting services for the whole hospital will be concentrated on the four lower floors of the two buildings.

The plans also include provisions for a psychiatric department, a clinical research unit, an eye section, and other specialized facilities, which up to now have been lacking or inadequate.

U.S.P.H.S. Offers Courses for Health Workers

WASHINGTON, D.C.—A series of training courses for physicians and other professional health personnel who would be called to duty in the event of a national emergency was held here last month by the U.S. Public Health Service.

The training covered the emergency health and sanitation activities necessary for defense against chemical, biological and radiological warfare. Medical officers, sanitation engineers, nurses and dentists took part in the program. Each trainee is a member of the commissioned reserve corps of the Public Health Service.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Hoover Commission Recommends Revision of Federal Services

WASHINGTON, D.C.—The Hoover Commission on organization of the executive branch of the government recommended last month that federal health services should be reorganized to:

1. Permit a more closely coordinated pattern of medical and hospital services in the armed forces.

2. Consider closing certain Veterans Administration hospitals determined to be surplus.

3. Rescind authorizations and appropriations for construction of additional veterans general hospitals.

4. Dispose of, by sale or otherwise, any V.A. hospital which can no longer be operated effectively and economically.

5. Subject to verification a veteran's statement of inability to pay for hospitalization for nonservice-connected disability.

6. Require the veteran to assume a liability to pay for care of nonservice-connected disability if he can do so at some reasonable time in the future.

7. Furnish outpatient care to indigent veterans with nonservice-connected disabilities.

8. Consolidate all laws relating to veterans or veterans' benefits and in particular to medical treatment and domiciliary care benefits.

9. Terminate the provision of hospital and clinical services to American merchant seamen in U.S. Public Health Service hospitals.

10. Provide hospital and medical care of Coast and Geodetic Survey, Coast Guard, and Public Health Service personnel in military service facilities.

11. Close Public Health Service hospitals except for mental, drug addict, tuberculosis and Indian Service hospitals and the leprosarium.

12. Develop a voluntary contributory program of medical and hospitalization insurance, to be conducted through a pool of private health insurance agencies, for all civilian employes of the federal government on a prepayment basis using payroll deductions.

13. Develop for dependents of military personnel in the United States a voluntary contribution plan of medical and hospital insurance.

14. Develop for dependents of uniformed personnel of the Public Health Service, Coast Guard, and Coast and Geodetic Survey a voluntary contribution plan of medical care and hospital insurance.

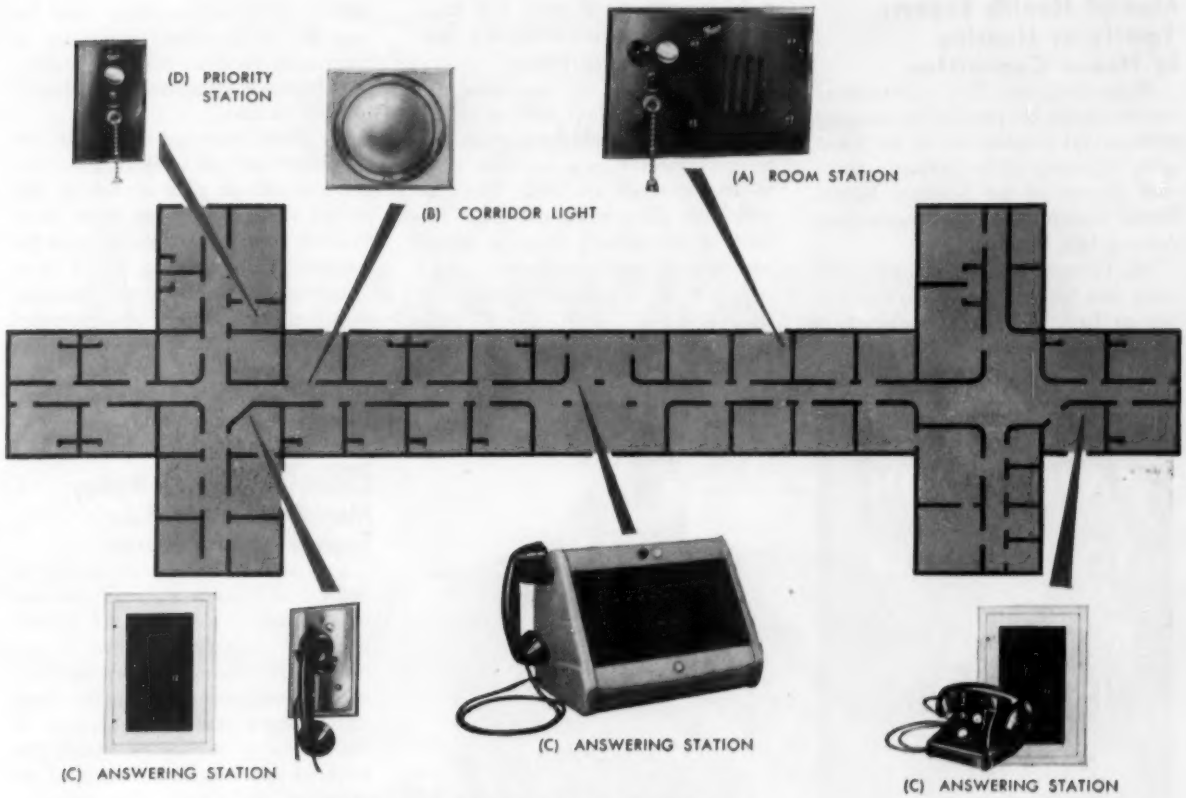
15. Establish a Federal Advisory Council of Health to be comprised of members of the medical profession, together with lay members with distinguished records in fields other than the medical profession, to serve at the will of the President.

The federal council would make recommendations for all health and medical programs of the federal government, it was recommended.

$21 Million California Medical Center Opens

BERKELEY, CALIF. — Recent dedication ceremonies at the University of California marked the opening of the new Herbert C. Moffitt Hospital and one unit of the medical sciences building here. Dr. Joseph C. Hinsey, president, joint administrative board of New York-Cornell University Medical College, was the speaker.

Begun in 1950, the two structures are the first to be completed in the university's program to modernize its medical education facilities.



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Mental Health Experts Testify at Hearing in House Committee

WASHINGTON, D.C.—Personnel training is the key problem in bringing state mental hospitals out of the Nineteenth Century, Mike Gorman, executive director of the National Mental Health Committee, told a congressional hearing here last month.

Mr. Gorman urged the House interstate and foreign commerce committee to back what was described in the hearings as the "community approach" to treatment of mental illness, with integration of state and local facilities and utilization of day hospitals and "half-way houses."

Speaking before the committee, Dr. Daniel Blain, medical director of the American Psychiatric Association, said mental illness is not hopeless when modern methods are used. The time will come soon when the great majority of the mentally ill can be treated and returned to the community in a relatively short period of time, Dr. Blain said.

To achieve this objective, the community approach that has been found effective in other countries must be used, Dr. Blain added. Integration of community facilities helps to prevent and shorten hospitalization for mental patients, he said.

Dr. Blain proposed amending the Administration's health legislation program to include pilot studies of "facilities which will foster better coordination between the hospital and the community in carrying out a total treatment program for the mentally ill." He urged support of a proposed three-year, $1,250,000 study of the problem, expressing confidence that private resources would match federal funds to produce the study.

Selective Service Policy May Deplete Nation's Supply of Physicians

CHICAGO.—The nation's supply of medical teachers and researchers may be seriously depleted if the present policy of drafting physicians is continued, Dr. Dean F. Smiley, secretary of the Association of American Medical Colleges, said in an editorial in the *Journal of Medical Education*. The editorial asked for reevaluation of the physician draft, with more attention to the needs of medical education and research.

Since the beginning of World War II, Selective Service has delivered as many doctors to the armed forces as they estimated they would need, Dr. Smiley pointed out. In some essential respects, however, Selective Service requirements are neither fixed nor fair, he added.

"Military service or the threat of it has made long-term planning almost impossible for these men," he stated. "More than 3000 graduate students in the sciences have had their careers interrupted or terminated by military service. How long can this nation continue to ignore the need for medical teachers and researchers before we find ourselves falling behind Russia in our ability both to train new physicians and to carry out important life-saving research?"

Dr. McIntire Heads I.C.S.

CHICAGO.—V. Adm. Ross T. McIntire (retired), former surgeon general of the navy, has been appointed executive director of the International College of Surgeons, it was announced at college headquarters here last month.

Dr. McIntire is the first full-time executive director the college has had.

May Need Extension of Doctor Draft Law After June 30, Rusk Reports

NEW YORK.—The doctor draft will have to be extended beyond expiration of the present law June 30 this year if essential needs of the armed forces medical services are to be met, Dr. Howard A. Rusk said here last month in a *New York Times* article.

The American Medical Association has stated that the needs of the armed services can be met through voluntary enlistments, without extending the doctor draft.

Despite substantial manpower savings achieved in the medical services in recent years, Dr. Rusk said, most authorities now have concluded that continuance of the doctor draft law is a necessary defense measure. "The doctor draft law is clearly discriminatory class legislation," Dr. Rusk acknowledged, "as men are drafted solely on the basis of their profession. It is regrettable that such legislation is necessary for national defense.

"Its essentiality is further evidence that our present national supply of physicians and dentists is not sufficient to meet the normal peacetime needs of our nation, in view of our rapid population growth. Nor does it permit even the minimum margin of reserve health manpower essential for mobilization and defense."

The armed forces use physicians at an over-all rate of about three times, and dentists at about four times, that of the civilian population, Dr. Rusk explained.

"Health manpower planners hoped for some time that extension of the doctor draft might not be necessary when it expires in June," he said. "They hoped also that the needs of the armed forces for physicians and dentists could be met by younger men just completing their professional education who were due for military service under the basic Selective Service Act.

"Despite the substantial manpower savings that the armed forces have achieved, studies have led most authorities to the conclusion that continuance of the doctor draft law is necessary as a defense measure.

"Even when the number of new medical school graduates due for military service under the basic Selective Service Act becomes sufficient to meet military needs, the armed forces, without special legislation, would find it extremely difficult to obtain an adequate supply of senior medical officers and specialists.

"Plans are now being made whereby a number of these new graduates will be deferred from military service for three years to complete advanced specialty training, thus ensuring the armed forces of an adequate supply of specialists in the future."

Provident Hospital Tops Goal in Fund Drive

CHICAGO.—The Provident Hospital here announced it had raised $105,836 against a $100,000 quota, in a campaign to meet current deficits. "The hospital has been tided over in its perpetual struggle to aid the medically indigent on the south side and add to the nation's supply of trained nurses, interns and residents," said Edward B. Busby, general campaign chairman for the hospital's board of trustees.

Of the total amount raised, the report said, approximately $65,000 came from special gifts, $19,000 from the local community drive, $11,000 from the business division, and $10,000 from the women's group.

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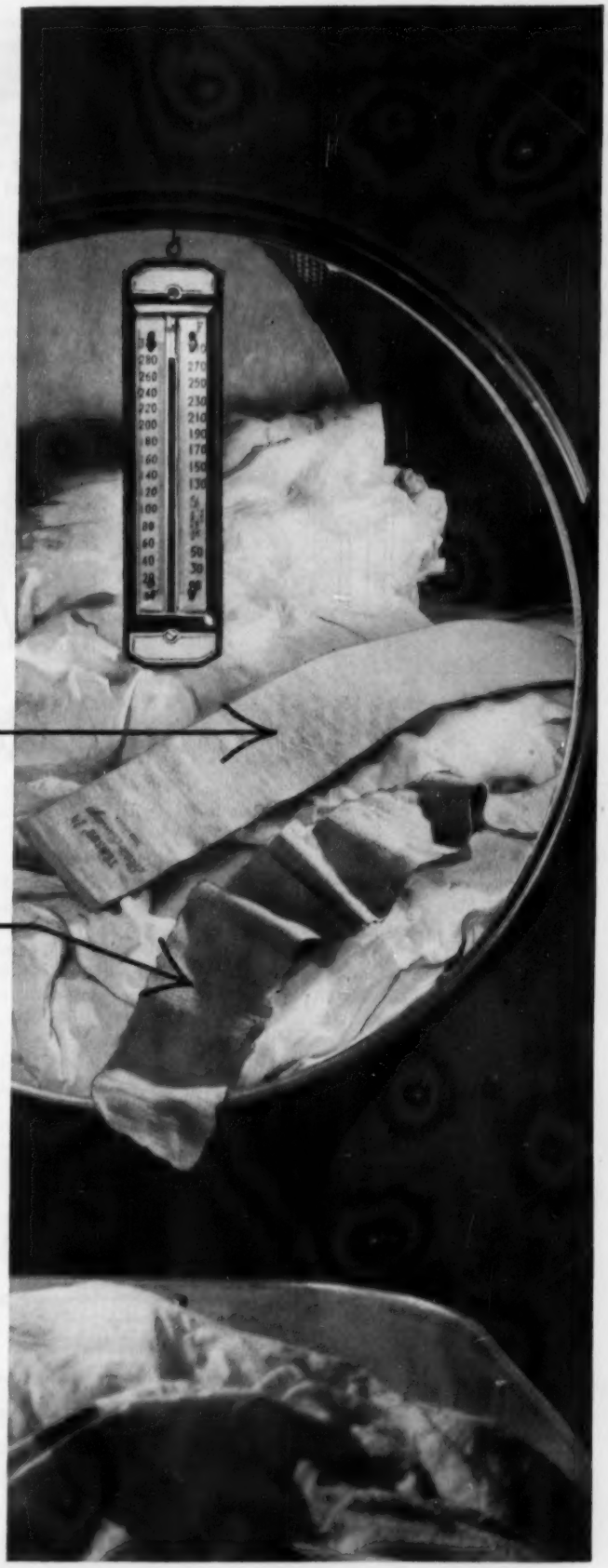

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F.H.A.-Type Financing of Hospitals Questioned

(*Continued From Page 54*)

record as to quality and have been declining as an element in the American hospital scene. Government policy should not encourage this type of institution. For example, a large majority of existing nursing homes are proprietary. Experience with such homes does not lead us to depend on them as agencies for meeting the problems of chronic illness.

"If the loans were limited to nonprofit organizations, the scheme would still be objectionable in principle but would be comparatively harmless in practice, because it would not be widely used by nonprofit institutions. Mortgage loan insurance would provide an alternative to the well established Hill-Burton method of federal aid for the construction of various medical facilities. The new proposal opens the door to proprietary facilities, whereas the Hill-Burton method is limited to nonprofit facilities. What is even more important, the new proposal provides no federal standards and no state planning procedure, as in Hill-Burton. It gives the Secretary of Health, Education and Welfare complete discretion in framing the regulations for the administration of this proposal, with no reference either to the states or to the Federal Hospital Council, which must pass on all federal regulations under Hill-Burton.

"The American Hospital Association and other hospital groups should oppose the proposal in its present form," the economist concluded. "At very least, these groups should propose amendments which would (a) limit the proposal to nonprofit facilities, and (b) provide that the same standards and procedures required under the Hill-Burton Act should apply to all projects receiving mortgage loan insurance."

A.M.A. Opposes President's Health Reinsurance Plan

CHICAGO.—The American Medical Association opposes President Eisenhower's proposal for a medical care reinsurance program, according to a statement released at A.M.A. headquarters here recently. The A.M.A. said the proposed federal reinsurance corporation "will not achieve the desired results."

In a news release, the association commended the President for his belief in voluntary health insurance and his efforts to encourage its expansion. The association was in complete accord with the purposes of the proposed legislation, the statement said.

The A.M.A. board of trustees has not taken a formal stand on the new reinsurance proposal, it was indicated. The board objected to a similar program advocated by the President last year, it was pointed out.

The A.M.A. also took no formal position on the President's recommendations for mortgage loans to provide funds for construction of health facilities, or for the proposal to improve arrangements for financing health service for public assistance recipients. A.M.A. position on these proposals would have to await study of specific legislation, it was explained.

In its statement, the A.M.A. supported the President's proposals to intensify research in mental illness, provide aid for training practical nurses, speed rehabilitation of the disabled, expand grants in aid for public health departments, and establish training programs in public health.

Iowa Doctors Move to Establish Hospital

(*Continued From Page 64*)

tients and "betterment of the community," he would be in favor of it. "But if it is a pressure deal to force local hospitals into a situation which would be unfavorable to them, then I would be against it," he added.

Both the Jennie Edmundson and Mercy hospitals are plaintiffs in the Iowa Hospital Association's suit for declaratory judgment, filed early in February.

Plainly referring to the hospital suit, the Pottawattami society's resolution said: "There has been an increasing effort on the part of politicians in their zealous bent for self-perpetuation . . . attempting to develop a public acceptance of socialized medicine. The American Hospital Association and its members have ostensibly become the unwitting tool of the advocates of socialized medicine as exemplified by their willingness to openly and overtly flout the laws of Iowa and usurp the functions of the medical profession in deprivation of the right of individuals to freely select physicians."

COMING EVENTS

AMERICAN ASSOCIATION OF INDUSTRIAL NURSES, Annual Conference, Memorial Auditorium, Buffalo, N.Y., April 25-29.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, LaSalle Hotel, Chicago, Oct. 3-7.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Traymore, Atlantic City, N.J., Sept. 17-19.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 19-22.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Medical Record Librarian Training School, Chicago, May 23-27, Annual Meeting, Statler Hotel, Washington, D.C., Oct. 30-Nov. 2.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 25-28.

CALIFORNIA SOCIETY OF X-RAY TECHNICIANS, 17th Annual Convention. U. S. Grant Hotel, San Diego, April 14-17.

CANADIAN HOSPITAL ASSOCIATION, Biennial Meeting, Chateau Laurier Hotel, Ottawa, Ont., May 9-11.

CAROLINAS - VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 21, 22.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, May 16-19.

ILLINOIS HOSPITAL ASSOCIATION, Annual Meeting, Springfield, Dec. 1, 2.

INTERNATIONAL HOSPITAL CONGRESS, Lucerne, Switzerland, May 30-June 3.

KENTUCKY HOSPITAL ASSOCIATION, Seelbach Hotel, Louisville, April 12-14.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Conference, Shoreham Hotel, Washington, D.C., Nov. 7-9.

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 25-27.

MID-WEST HOSPITAL ASSOCIATION, President Hotel, Kansas City, Mo., April 27-29.

NATIONAL COUNCIL OF HOSPITAL AUXILIARIES OF CANADA, Biennial Meeting, Chateau Laurier, Ottawa, Ont., May 9-11.

NEW YORK STATE ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Annual Meeting, Hotel Ten Eyck, Albany, May 4-6.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Spring Conference, Marvin-Hugitt Hotel, Huron, April 18, 19.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga. April 20-22.

TENNESSEE HOSPITAL ASSOCIATION, Chattanooga, May 19-21.

TEXAS HOSPITAL ASSOCIATION, Hotel Shamrock, Houston, April 12-14.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-5.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 11-13.

WASHINGTON STATE HOSPITAL ASSOCIATION, Mid-Year Meeting, Winthrop Hotel, Tacoma, March 30; Annual Meeting, Davenport Hotel, Spokane, Oct. 19, 20.

1956

SOUTHEASTERN HOSPITAL CONFERENCE, Miami Beach, Fla., April 18-20.

A.C.S. Reports Success in Publicity Campaign Against Bad Surgical Practices

CLEVELAND.—The American College of Surgeons' public education campaign against unethical practices in surgery has moved into low gear, Dr. Paul R. Hawley, director of the college, indicated in an address at a sectional meeting here last month. No further publicity on unethical practices is contemplated at this time, Dr. Hawley said.

The major objective of the public campaign was to "arouse the conscience of the medical profession to the need of eradicating such practices as unjustified surgery, ghost surgery, and fee splitting," Dr. Hawley said. This objective has been achieved, he added. "More and more local surgical societies are being organized for the specific purpose of eradicating evil practices," he explained. "More and more hospital staffs are taking positive action to rid themselves of violators. The principal reason for success in this effort is the cooperation of the public. This has been achieved solely by the publicity campaign."

Reviewing the controversy beginning in 1952 when members of the board of regents and other officers of the college sat down around a table with the nation's leading science writers and engaged in a frank discussion with the press unprecedented in the activities of national medical organizations, Dr. Hawley spoke as follows:

"About three years ago, the regents stepped up the college's program for the eradication of evil practices in surgery. Because, in the opinion of the regents, little could be accomplished so long as these sins were hidden, they were given the spotlight of publicity. The cooperation of an enlightened public was essential, if anything were to be accomplished. There are many precedents for this; one is that the social evil of venereal disease could never be successfully attacked until it was brought into the open.

"I do not need to describe to you the initial reactions to the publicity campaign inaugurated by the board of regents. Many doctors, among them the most respected in the profession, applauded the action of the regents. There were others, among them certain medical organizations, who condemned the college in violent terms. If my observations were correct, however, the majority of the profession, while recog-

(*Continued on Page* 168)

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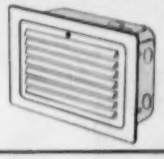

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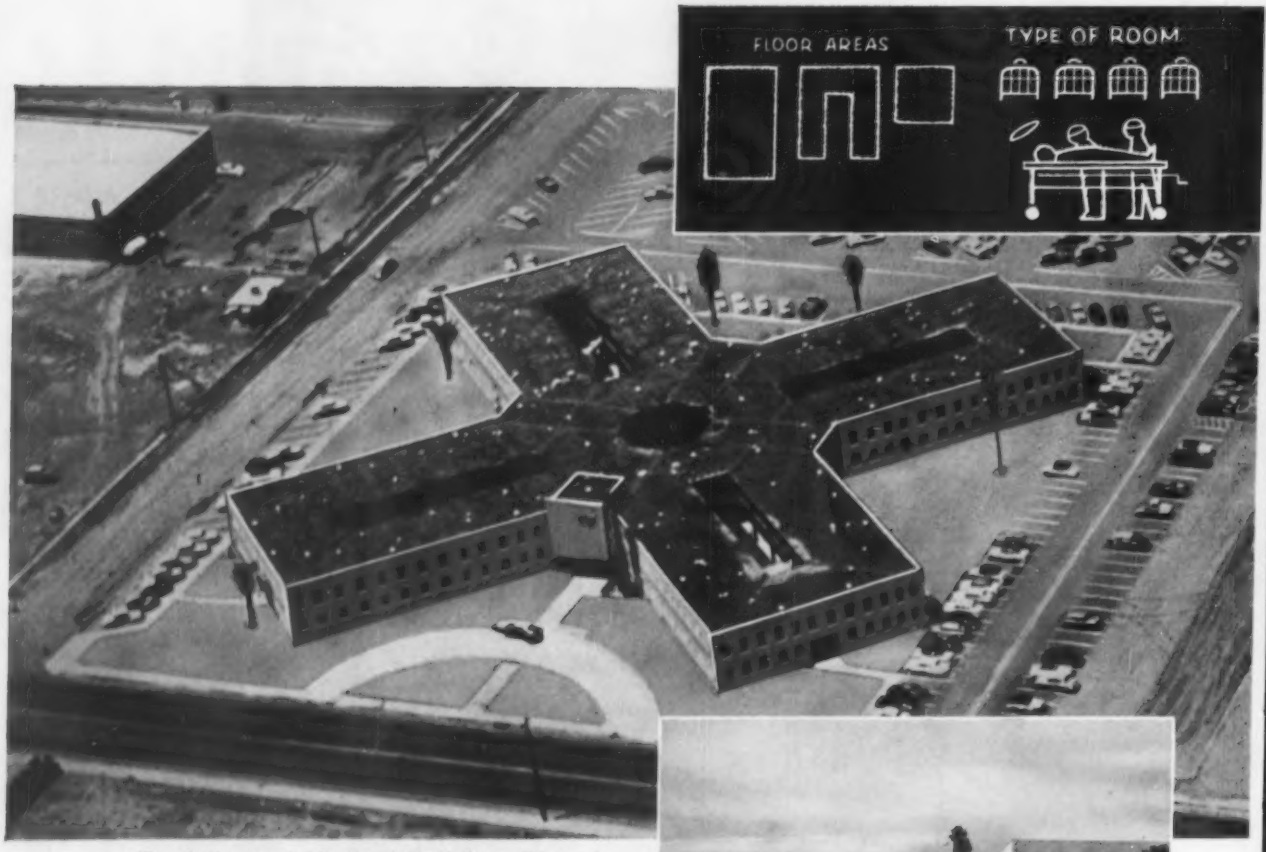

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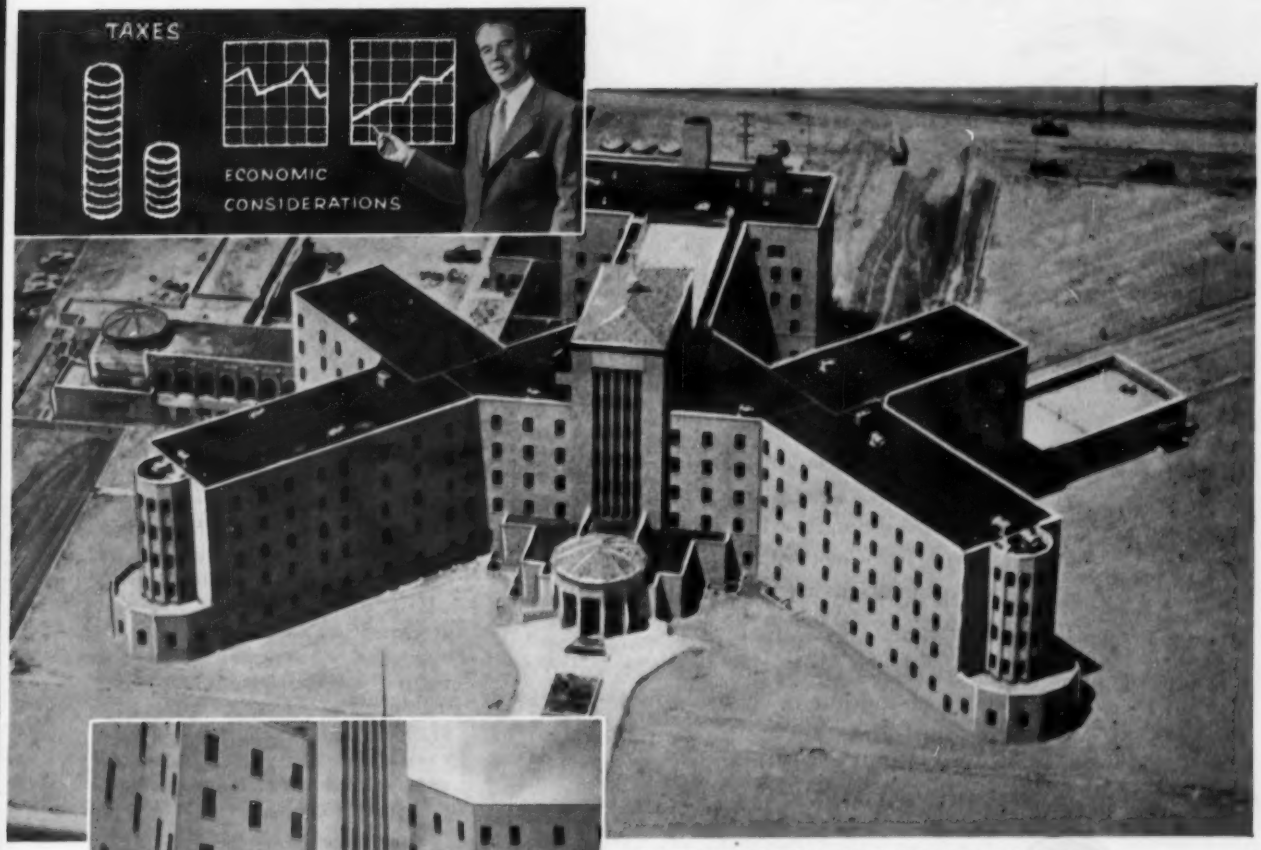

St. Joseph's Hospital, Phoenix, Arizona.
Two York Turbo Water Cooling Systems, totaling 440 tons refrigeration capacity, supply cooling for 26 Dual Duct systems and 48 separate exhaust systems. Architect—Lescher & Mahoney; General Contractor—Del E. Webb Construction Co.; Mechanical Contractor—Valley Sheet Metal Co.

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(*Continued From Page* 164)
nizing the need for action, appeared to be rather stunned by the audacity of the college in exposing secret sin, but reserved an opinion upon the propriety of the college's action. On the other hand, there was no doubt of the reaction of the lay public. It gave almost unanimous approval; and the press of the nation printed many compliments on the college.

"It has been interesting to follow the more mature reaction of the profession, after the initial sound and fury died away. By no means all of the profession have come to the college's way of thinking—either in principle or in method. We have, at least, accomplished one thing—we have solidified those elements in the profession which desire the unrestricted perpetuation of such evils as fee splitting and ghost surgery. So now, at least, we know where the opposition is.

"On the other hand, there is much evidence that the college has aroused the consciences of many in the profession, who have always themselves been ethical, but who have become apathetic in the face of evils existing without a protest from a responsible source. More and more local surgical societies are being organized for the specific purpose of eradicating evil practices; and more and more hospital staffs are taking positive action to rid themselves of violators of ethics. The college office receives numerous inquiries about ways and means to accomplish this.

"So, the first objective of the college's publicity campaign has been achieved. We realize fully that the job to be done can be done only at the local level—by doctors themselves in each community. Now that this has been started, there is no necessity for further action at this time by the college, except to render assistance when it is requested. For this reason, no further publicity is contemplated by the board of regents. It might be expected, however, if the movement to curb bad practices begins to drag its feet, that the regents would consider reviving the publicity program. The present situation is that a fire has been started which must be kept burning. If the fire shows signs of dying out, it must be given more draft. At the same time, we must not forget that a promising blaze can be put out with too much draft.

"The principal reason for greater success in this effort is the cooperation of the public. This has been achieved solely by the publicity campaign. At the present time, most of the evidence of unethical practices comes from patients. All such charges are carefully and quietly investigated. The large proportion are substantiated, with the result that an increasing number of Fellows are expelled each year by the regents. The effect of this reaches much farther than the individuals involved. Action in each such case exerts a restraining action upon others," Dr. Hawley concluded.

Children's Hospital Heads Organize Into Council

PHILADELPHIA. — The Council of Children's Hospital Executives held its founding meeting here March 17 and 18 in connection with the centennial ceremonies of Children's Hospital of Philadelphia.

Edmund J. Shea, administrator of James Whitcomb Riley Hospital for Children and the Indiana University Medical Center, Indianapolis, and chairman of the council, explained that the idea for the formation of the

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says ROBERT D. CADMUS, M.D., Director
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"May I take this opportunity," writes Dr. Cadmus, "to thank Pittsburgh color consultants for helping us to create at Chapel Hill a new and beautiful hospital. This monumental task has required the talents and efforts of many people over a long period of time. But it was the excellent application of the principles of COLOR DYNAMICS which put the finishing touches to this great medical center.

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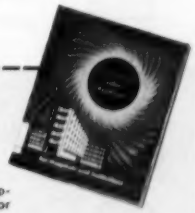

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council had grown out of a desire on the part of administrators of children's hospitals for an opportunity to be able to exchange experiences on mutual problems and thus improve the service rendered by these specialized hospitals.

Charter members of the council include children's hospitals in Boston, Chicago, Cincinnati, Denver, Indianapolis, Los Angeles, Milwaukee, Philadelphia, Pittsburgh, Buffalo, N.Y., and Washington, D.C. These hospitals provide more than 2500 beds for juvenile patients.

Take Public Hospitals Out of Politics, Chicago Newspaper Demands

CHICAGO.—Public hospitals do not have to be mismanaged, nor do they have to be used by politicians to dispense jobs and favors, the *Chicago Tribune* said in an editorial here last month.

The editorial followed publication of a series of articles on Cook County Hospital here, where instances of waste and inefficiency owing to political patronage were reported.

"Large general hospitals in other cities and states have been taken out of politics," the *Tribune* editorial said. "Political mismanagement might be tolerable at a county farm for goats. It can be endured in county buildings and agencies which are not concerned with human lives. But a systematic political traffic in misery is not tolerable."

Among other conditions at Cook County Hospital, the articles by Reporter Robert Wiedrich found:

1. The hospital has 209 general floor nurses on duty and needs from 500 to 800.

2. There are 500 political patronage jobs at the 3000 bed hospital, including janitors, guards, elevator operators, food handlers and maids.

3. Under the County Hospital wage scale, nurses get $305 to $325 a month, and housekeepers without training get the same amount. Other wages: window washers, $410; janitors, $301; maids, $255; supply clerks, $240 to $310; ward attendants, $258 to $288.

4. Patronage employes refuse to perform unpleasant tasks but may not be discharged. "They'll tell you where to go if you give them an order not to their liking," a nurse was reported as saying. "They'll tell you they can go to their political sponsor if you don't like it. I've reported bad workers and lazy ones, but nothing ever happened. They kept their jobs."

5. A single nurse may have charge of 150 to 175 patients on night duty, with only three or four attendants to help her. "It is quite possible some patients have died in the long night hours because there was no one to watch them closely even though they were critically ill," a former medical staff member reportedly said.

6. Members of the attending medical staff are required to devote 18 hours a month to the hospital. Most attending staff members devote six to eight hours a week, it was reported, but "many of the attending men are too busy with their teaching and private practice; generous estimate of the time devoted by many of them is two 1½ hour visits a week."

7. Sheets on hospital beds are changed only once a week, a County nurse charged, recalling instances in which attendants were caught selling clean sheets and gowns to patients.

8. Sometimes patients are held beyond the normal time of discharge, notwithstanding severe overcrowding, for political reasons.

(*Continued on Page* 170)

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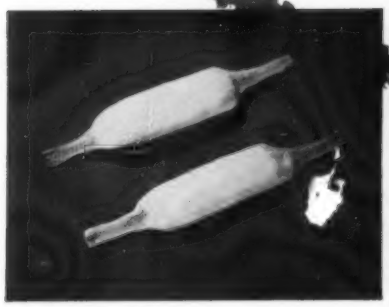

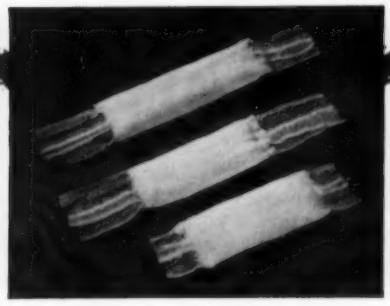

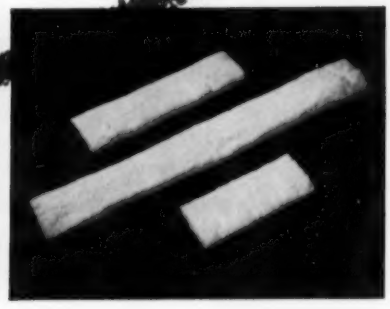

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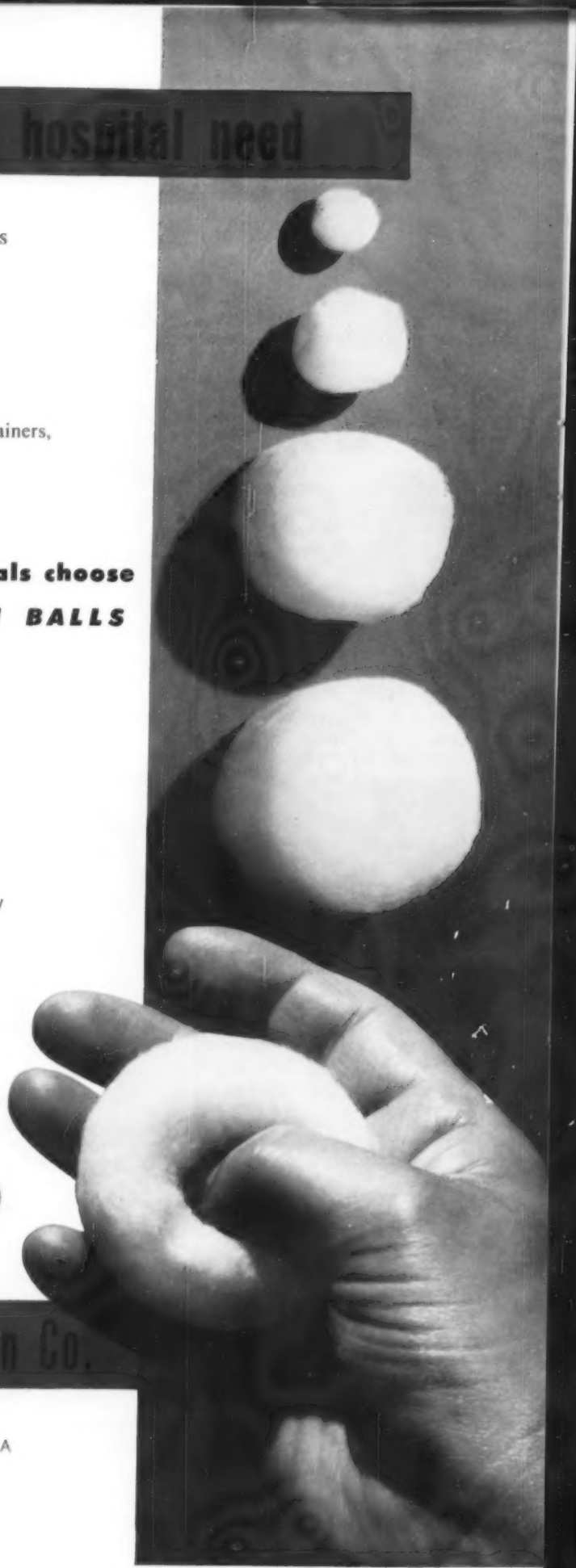

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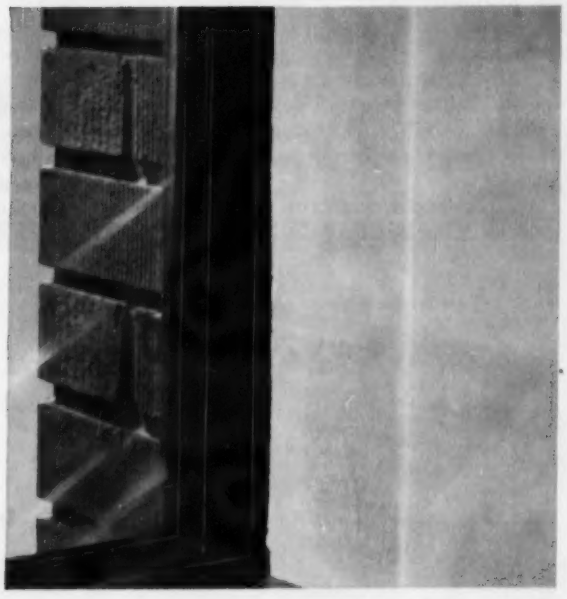

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Driving rain kept soaking right through the brick walls of this Buffalo, N. Y. laboratory. Typical damage to interior paint only six months old is shown at left.

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In his concluding article, Mr. Wiedrich reported County Hospital authorities felt there was nothing wrong with having 500 patronage jobs at the institution.

Other authorities disagree. Dr. Paul R. Hawley, director of the American College of Surgeons, was quoted as stating:

"Patronage is no good. Even a scrubwoman contributes something to patient care, and patronage does not always produce the best type of employe."

Another hospital authority, quoted anonymously by the *Tribune* reporter, said, "If the politicians were sincere in their wishes to operate the hospital efficiently, they would appoint a lay board of leading citizens who would serve without pay, set policy, and run the hospital without political interference."

Many municipal hospitals have such nonpolitical boards, it was explained. In an editorial, the *Tribune* said the Municipal Tuberculosis Sanitarium had been turned into a "model of efficiency," thanks to a board of distinguished physicians.

Queens Jury Accuses Some Private Hospitals

NEW YORK. — "Negligence and disregard for the patient" characterize care in some of the private hospitals in Queens borough, reported a Queens County grand jury recently. The jury's presentment was made in light of the report of a two-year investigation of private hospitals in the borough. The result of the investigation for private hospitals in New York City will be a revision of regulations affecting their operation, Dr. Luther H. Gulick, city administrator, announced.

The investigation, the panel asserted, had revealed fee splitting and kick-back practices in some of the hospitals, as well as carelessness and inefficiency on the part of doctors, nurses and other hospital personnel. The panel also criticized the practice of permitting nurses to administer anesthesia to patients without a physician anesthetist in attendance.

"The presentment," Dr. Gulick said, "is not an indictment of medical carelessness in city hospitals or in the great voluntary nonprofit hospitals. It is an indictment of a few unnamed private proprietary hospitals. There are apparently some bad apples in the barrel."

Yale Starts Program in Medical Sociology

NEW HAVEN, CONN. — A new program in medical sociology at Yale University will give graduate students in the social sciences an opportunity to apply the knowledge and technics of sociology to the fields of medicine and public health.

The program is an attempt to bridge the gap between medicine and sociology, between the doctor and the society he serves, Edgar S. Furniss, provost of the university, explained.

Differences in the training of social scientists and of medical scientists make communication between these two groups of specialists difficult, it was explained. This is one of the problems in public health that the Yale program is designed to overcome.

August B. Hollingshead, professor of sociology at Yale, will be in charge of the medical sociology studies. The program is supported by grants totaling $67,000 and by tuition scholarships from the university, the announcement said.

Medical Schools to Produce 7500 Graduates by 1960

CHICAGO. — In the next five years the nation's medical schools will increase their output of graduates from the present figure of 6861 to 7300 or 7500, the American Medical Association reported in a 50 year survey of the development of medical schools.

The opening of five new medical schools will add to the greater number of graduates, said Dr. Edward L. Turner, secretary of the association's Council on Medical Education and Hospitals and author of the survey. Of the new medical schools, the University of California at Los Angeles will be the first to graduate a class—in June of this year. The other new medical schools are located at the University of Miami, Miami, Fla., Albert Einstein College of Medicine, New York, Seton Hall College of Medicine, Jersey City, N.J., and the University of Florida, Gainesville.

The universities of Mississippi, Missouri and West Virginia are planning to expand their medical schools, Dr. Turner reported.

In answer to the common criticism that medical schools accept only one applicant out of 10 or more, Dr. Turner stated that in 1953-54 one out of every 1.97 applicants was admitted to an approved school. The confusion might have originated, he said, from the fact that each student applied to at least three schools, so that in effect only one-third of the applications resulted in admissions. Approved medical schools, he continued, have increased their production of physicians by increasing student enrollment as much as finances, facilities and faculty have allowed.

While there were more graduates from medical schools in 1900 than there are now, it must be remembered, he said, that many of those schools were merely diploma mills and only about one-third of them could offer education that met acceptable standards.

Beware of This Canadian "House Doctor" or No

ORLANDO, FLA. — One of those credit office worries is reported in *News-Views* of the Florida Hospital Association in fair warning to all hospital administrators.

Joseph Marleau, the association newsletter reports, entered New England Baptist Hospital in Boston as a patient, giving his address in Montreal, P.Q. When, upon his recovery, the hospital bill was mailed to this address it was returned marked "Unknown." The bill was then mailed to the Rev. Edgar Marleau, whom the patient had given as his nearest relative, and the bill was returned with the following letter:

Geraldton, Ont.
Feb. 12, 1955

To whom it may concern:

This is to advise you that this Joseph Marleau is the best Joker I ever hear about. He goes from one hospital to another in the States and gets care free of charge and tells them to send the bill to Rev. Edgar Marleau. Three times this year I get bills in Rev. Marleau, who is dead for close to three years. Last year I got three bills also from Canadian Hospitals, but on your bill I find something new—he is a doctor. As far as I can see he might be a horse doctor, but a smart one. I am sending your bill back but I am sure that you will never collect it as the last one was from Florida.

Yours truly,
/a/ G. Lampron, P.P.

The newsletter describes Mr. (or Dr.) Marleau as a thin, tense, nervous person about 36 years old with light brown hair; a fairly prominent nose; 5 ft. 5 in. tall; weighs about 150 lbs.

INSTRUMENTS

to cut hospital accounting costs

Looking for more efficient operation . . . ways to cut cost corners . . . give better service? Hospitals from coast to coast have found a ready answer through standardizing on Burroughs. For example, here are four typical Burroughs machines that have, time and time again, demonstrated their outstanding value in hospital applications:

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Exact figuring is made easy with the famous Burroughs Adding Machine . . . subtracts as fast as it adds . . . prints ciphers automatically.

2

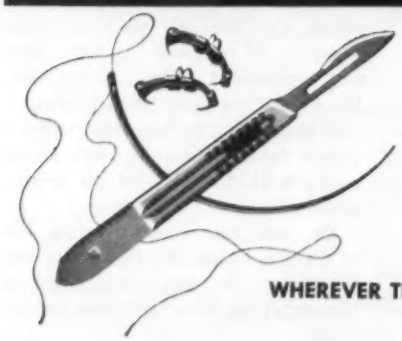
You can keep the line in your cafeteria moving with the Burroughs Cash Register . . . prints the price of each item and gives the total quickly.

3

Burroughs Cash Receipting and Validating machine gives extra protection . . . it validates the bill and receipt, and records all information on an audit tape.

4

Burroughs Sensimatic Accounting Machine handles patient accounting in the columnar plan or the ledger statement form . . . does any bookkeeping job.



So, to increase the efficiency of your hospital's operation, find out how you can use a Burroughs. Call the nearest branch office, or write Burroughs Corporation, Detroit 32, Michigan.

WHEREVER THERE'S BUSINESS THERE'S **Burroughs**

"Practice of Medicine" Course at Colorado Aids Medical Students

CHICAGO.—A new medical college course in the practice of medicine helps students decide whether to specialize or enter general practice, according to an article in the *Journal of Medical Education*, published by the Association of American Medical Colleges here.

The course is offered at the University of Colorado School of Medicine and is described in an article by Dr. Gertrude Weiss, associate professor and acting head of the department of preventive medicine at the school.

Offered in the junior year, the practice of medicine course is based on case history presentations, it was explained. Students have time to study the cases, which cover such problems as choice of locality and office space, relations with other doctors, fees, and other business problems in medical practice.

"At present, a question which perturbs many medical students is the decision to enter general practice or to specialize," the association stated. In the Colorado course, it was explained, this problem is handled by a panel discussion including a general practitioner, an obstetrician, a pediatrician and an internist. "Also, two general practitioners from small communities described their practice and the situations they face," Dr. Weiss said. "This was the first time the students had met and been taught by general practitioners, yet a poll taken at the end of the year showed that almost half the junior class intended to enter general practice."

Response to the course has been excellent, according to Dr. Weiss, and groups of students have requested some of the lecturers to meet with them privately to continue discussion of these topics.

Two-Year Nursing Course Approved in Pennsylvania

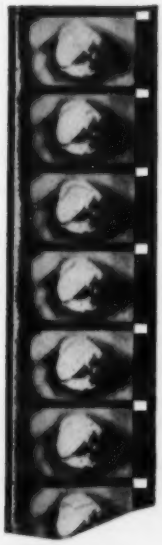
HARRISBURG, PA. — Approval has been given by the Pennsylvania Hospital Association to a two-year program of nursing education which will qualify graduates to take state board examinations, it was stated in a story in the March issue of the *Bulletin* of the Pennsylvania Hospital Association. The program will be inaugurated immediately at Pennsylvania Hospital, Philadelphia, under a $100,000 grant from the Hartford Foundation.

The experimental program is meant to prepare women for general duty nursing, the association explained. The theoretical part of the usual nurse training programs is to be reduced and a greater proportion of learning time is to be spent in closely supervised work on the wards.

N.Y.C. Department Official Has Been Reinstated in Job

NEW YORK. — Dr. Ferdinand Piazza, who a few months ago was demoted from his position as a general medical superintendent of New York City hospitals, has been reinstated, Dr. Basil C. MacLean, commissioner of hospitals for New York City, announced. The action against Dr. Piazza had been taken because it was found that he had been using a patient from one of the city's homes to do work for him on his private property.

Dr. MacLean stated that the loss of income which Dr. Piazza has suffered since the incident occurred in November has been "sufficient punishment."



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"Pheochromocytoma—a cause of hypertension"

An interesting film dealing with the diagnosis and treatment of a curable form of hypertension.

Illustrates the need for routine screening of hypertensive patients to rule out the presence of such a tumor.

Sound and Color
Running Time: 24 min.

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A film which dramatically illustrates the tranquilizing effect of Serpasil, a pure crystalline alkaloid known as reserpine.

An interesting presentation for viewing by members of the medical, pharmacy and nursing professions.

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Running Time: 15 min.

Booking Arrangements—It is suggested that requests be entered a minimum of 3 weeks prior to your intended showing date. If you wish, the necessary projection equipment and a qualified operator will be provided, without charge.
Requests for showings of these films should be directed to the nearest office of our distributing agents—
Ideal Pictures Corporation:

East—233-239 W. 42nd Street, New York 36, New York, Tel.: LAckawanna 4-0916
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West—4247 Piedmont Avenue, Oakland 11, California, Tel.: Piedmont 54886
Hawaii—1370 S. Beretania Street, Honolulu, T. H., Tel.: 65336

C I B A
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2/2056H

Dr. Allen Reports on Belgian Hospital Setup

BRUSSELS, BELGIUM.—Each of the three major political parties in Belgium owns and operates its own hospitals and conducts an insurance program for medical and hospital care," Dr. Wilmar M. Allen said in a report summarizing his first three months' experience here. Dr. Allen received a Fulbright grant as a consultant in hospital administration. He retired last year as director of the Hartford Hospital at Hartford, Conn.

The political party hospital systems have no connection with the government, which also has its hospital and medical insurance system, Dr. Allen said.

He attended the first congress of the Belgium Hospital Association soon after arriving in Belgium last November, Dr. Allen reported. "There were two general themes," he added, "education of the nurse, and the financing of hospitals, particularly by government. It was interesting that very few of the speakers were hospital administrators as we understand the term. The common practice here is to have a practicing physician on the staff as medical director, associated with a nurse or business administrator. The hospital situation is very interesting."

Offers Plans to Relieve Shortage of Nurses in New York State

ALBANY, N.Y.—A plan to relieve New York State's shortage of nurses has been proposed by the state department of education, the *New York Times* reports. In brief it calls for:

Legislation to provide more state scholarships for student nurses. According to the department of education, students in schools of nursing affiliated with colleges are eligible for state scholarships but students in nursing schools affiliated with hospitals are not. The latter, the department noted, make up 80 per cent of the nursing schools in the state.

An appropriation of $100,000 a year for a period of five years to experiment with and evaluate types of nurses' training.

A new recruitment program by hospitals and nursing schools to encourage registered nurses who have left the profession to return to it and to give them refresher courses.

A study by hospitals to determine whether they can improve administrative practices which relate to nurses and the budgeting, or use, of nurses, which have been found to vary greatly from one hospital to another.

"The shortage of professional nurses is not caused by lack of facilities for the preparation of nurses," the state department of education declared.

Heads Alumni Program at Washington University

ST. LOUIS.—Hugh R. Vickerstaff, assistant manager of Veterans Administration Hospital, Houston, Tex., has been elected president of the Alumni Association of the Department of Hospital Administration, Washington University. President-elect of the association is Jack W. Schrode, administrator of Wesley Hospital, Oklahoma City, Okla.

Other officers named include: vice president, Arthur E. Coltrin, administrator of Jane G. Phillips Memorial Hospital, Bartlesville, Okla.; secretary, Duane Johnson, administrator of University of Nebraska Hospital, Omaha, and treasurer, William C. Nichols, manager of Memorial Hospital of Laramie County, Cheyenne, Wyo.

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ABOUT PEOPLE

(*Continued From Page* 83)

10 years. Mr. Mason will continue in an advisory capacity. Mr. Green is a graduate in hospital administration from Northwestern University and served his administrative residency at Provident Hospital.

Kenneth A. Frisbie, finance officer of Veterans Administration Hospital, Hines, Ill., has been named assistant manager of the V.A. hospital, Seattle, succeeding **Marion F. Reagar,** who is now at the V.A. hospital in Oakland, Calif.

Laurel M. Jones has been named administrator of Washington County Hospital, Chipley, Fla.

Dr. Frederick MacCurdy, administrator of North Broward General Hospital, Fort Lauderdale, Fla., has announced his resignation. His successor is **Robert M. Gantt Jr.**

Dr. William W. Fellows, manager of Veterans Administration Research Hospital, Chicago, has been named assistant chief medical director for planning in the central office of the Veterans Administration, Washington, D.C. Dr. Fellows succeeds **Dr. Kelso A. Carroll,** who has been appointed manager of the V.A. center, Bay Pines, Fla. Dr. Fellows received his medical degree from New York University-Bellevue Medical School. Formerly he was a member of the staff of the V.A. hospital, Aspinwall, Pa., and served as manager of the V.A. hospital, Albany, N.Y. Dr. Fellows is a diplomate of the American Board of Surgery.

Eugene G. Edwards, administrator of Hiawatha Community Hospital, Hiawatha, Kan., has been named assistant superintendent of Bryan Memorial Hospital, Lincoln, Neb. In June Mr. Edwards will succeed **Dr. E. C. McDade** as superintendent. A graduate in hospital administration from Washington University, Mr. Edwards served his administrative residency at Fitzsimons Army Hospital, Denver. He is a nominee of the American College of Hospital Administrators and a member of the American Hospital Association. Mr. Edwards will be succeeded at Hiawatha by **Gary Bricker,** who retired from the army recently with the rank of lieutenant-colonel.

William K. Hinds, manager of the Veterans Administration Center, Jackson, Miss., has become manager of the V.A. center at Shreveport, La., succeeding the late **Durell A. Hiller. A. W. Woolford,** manager of V.A. hospital, Montgomery, Ala., has been named manager at Jackson V.A. hospital, and he is succeeded at Montgomery by **Dr. John S. Herring,** who has been chief of professional services at Veterans Administration Hospital, Memphis, Tenn.

Dr. Daniel R. Robinson, chief of professional services of Veterans Administration Hospital, Indianapolis, has been appointed manager of the V.A. hospital, Dwight, Ill. He succeeds **Dr. Joseph L. Campbell,** who resigned last November. Dr. Robinson received his medical degree from the University of Maryland. He is a graduate in hospital administration from Johns Hopkins School of Public Health and Hygiene, Baltimore. Dr. Robinson joined the Veterans Administration in 1953 as assistant chief of professional services of the V.A. hospital, Fort Howard, Md.

Dr. Alfred L. Cornwell, assistant administrator and purchasing agent of Robeson County Memorial Hospital, Lumberton, N.C., has become administrator of Dunn Hospital, Dunn, N.C. Dr. Cornwell served his internship in

hospital administration at Watts Hospital, Durham, N.C., then became administrative assistant there.

Robert E. Nicholson is now administrator of Dade County Hospital and Homes, Miami, Fla.

Helen Smith Clugston, formerly a member of the nursing staff of Girard General Hospital, Girard, Kan., has been appointed administrator there.

L. G. Parrish, superintendent of Memorial Hospital, Manitowoc, Wis., has become superintendent of Clinton Memorial Hospital, St. Johns, Mich., succeeding **Chester E. Teske,** who has resigned. Before going to the Manitowoc hospital in 1952, Mr. Parrish had been superintendent of Sunbury Community Hospital, Sunbury, Pa.

Uiza Phillips, administrator of Sedgwick County Hospital and Clinic, Wichita, Kan., has been named administrator of Mahaska Hospital, Oskaloosa, Iowa, succeeding **Marvin Nichols,** who resigned last November. Mr. Phillips has been in the field of hospital administration for some 30 years; he has served as administrator of Christian Welfare Hospital, East St. Louis, Ill., of Nashville General Hospital, Nashville, Tenn., and of Trinity Hospital, Dodge City, Kan.

Samuel Janzen, administrator of Kiowa County Memorial Hospital, Greensburg, Kan., has been appointed administrator of Valley View Hospital, Glenwood Springs, Colo.

J. Sam Nesbit Jr., superintendent of Wallace Thompson Hospital, Union, S.C., has become superintendent of Aiken County Hospital, Aiken, S.C.

Col. Robert Lee Black, retiring chief of the medical service corps of the U.S. Army, has become administrator of Memorial Medical Center, which is under construction at Williamson, W.Va.

Dr. Michael L. Matte, manager of the Veterans Administration Hospital, Denver, has been named manager of V.A. Research Hospital, Chicago, succeeding **Dr. William W. Fellows,** now assistant chief medical director for planning in the V.A.'s department of medicine and surgery, Washington, D.C. **Dr. Harold M. Engle,** manager of the V.A. hospital, Salt Lake City, succeeds Dr. Matte at Denver. **Dr. Thomas O. Lake,** chief of professional services of Veterans Administration Hospital, Oakland, Calif., is now manager of the Salt Lake City V.A. hospital.

Kenneth E. Brooks, administrator of Hayswood Hospital, Maysville, Ky., has been named regional chairman of the careers committee of the Kentucky League for Nursing. Mr. Brooks' region includes 15 counties.

Department Heads

Mrs. Alta M. La Belle, former housekeeping director at Michael Reese Hospital, Chicago, has accepted the position of executive housekeeper of Providence Memorial Hospital, El Paso, Tex. Following her resignation from Michael Reese Mrs. La Belle engaged in housekeeping consultation work. Most recently, she has been consultant to the Veterans Administration and set up the housekeeping organization in V.A. hospitals. As part of her program of reorganizing the V.A. housekeeping departments, Mrs. La Belle prepared a series of training manuals for housekeeping employes. She is senior author of "Administrative Housekeeping," published in 1951 by G. P. Putnam's Sons, New York City, and is a member of the editorial advisory board of The Modern Hospital.

Jean Zacharias, formerly of St. Luke's Hospital, San Francisco, has been appointed executive housekeeper of O'Connor Hospital, San Jose, Calif. Mrs. Zacharias had previously been ex-

Now holds standard #200, 12"x20" pans!

THE all-new TOASTMASTER DE LUXE HOT-FOOD SERVER

Holds cooked foods at the peak of perfection for hours!

New ready-reference instruction tray shows recommended temperature and humidity settings.

New "Hot" and "Cold" indicator . . . can be set to show when food is ready to serve.

New cool, finger-touch, recessed Bakelite handles.

New easy-to-use humidity regulator provides exact moisture control for each drawer.

New recessed thermostat . . . signal light indicates when unit is in use.

2-drawer De Luxe Model $275.00†

4-Drawer De Luxe Model $435.00†

3-Drawer Model $375.00†

THE MOST PROFITABLE UNIT OF ITS KIND!

Now you can safely cook ahead to meet peak demands.

Now cooked foods can be transferred in standard-size pans.

Now you can eliminate food losses caused by shrinkage, drying out and loss of flavor.

Drawers open all the way, measure 5¼" deep x 22½" long x 13½" wide, to accommodate #200 pans.

Drawers, drawer tops and roller channels come out completely for easy cleaning. Self-locking latch.

Unique six-sided air circulation around drawers keeps food uniformly moist or crisp as desired.

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TRADE-IN OFFER ON NEW POWERMATIC TOASTER EXPIRES APRIL 30!

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†Prices slightly higher in Pacific Coast states.

TOASTMASTER DE LUXE HOT-FOOD SERVER

ecutive housekeeper of Passavant Memorial Hospital, Chicago, St. Luke's Hospital, Milwaukee, and Presbyterian Hospital, Chicago.

Lavonne M. Frey, associate professor and chairman of the department of psychiatric nursing of the school of nursing at the University of Pittsburgh, has been named superintendent of nursing and of the school of nursing of St. Elizabeth's Hospital, Washington, D.C. The appointment is effective August 1. Miss Frey is a graduate of the school of nursing at St. Elizabeth's Hospital. Formerly she was a member of the staff of New Jersey State Hospital, Greystone Park. In 1940 Miss Frey went to Sheppard and Enoch Pratt Hospital, Towson, Md., and in 1946 became director of nursing there. She is a member of the American Nurses' Association and of the National League for Nursing.

Mildred Banning, dietitian of Central Dispensary and Emergency Hospital, Washington, D.C., is now managing dietitian of Alexandria Hospital, Alexandria. A graduate of Iowa State University, Mrs. Banning has been affiliated with St. Mary's Hospital, Rochester, Minn., and Mary and Elizabeth Hospital, Louisville, Ky. At the same time it was announced that **Jane Meehan,** therapeutic dietitian of Presbyterian Hospital, Philadelphia, is now assistant managing dietitian at Alexandria Hospital.

Charles F. Donovan, formerly at the Medical Center of Jersey City, Jersey City, N.J., is now purchasing agent of Valley Hospital, Ridgewood, N.J.

John R. Mote has been appointed personnel director of Methodist Hospital, Indianapolis. A graduate of DePauw University, Mr. Mote has been engaged in industrial personnel management. Most recently he has been personnel director of Metal Auto Parts Co., Indianapolis.

Miscellaneous


J. W. Castellucci

John W. Castellucci, formerly assistant director of Michigan Medical Service, has been appointed executive director of the Blue Shield Commission, Chicago. The commission serves as national coordinating agency for the 77 Blue Shield medical care plans. Mr. Castellucci has served as acting director of the commission since the resignation of **Frank E. Smith** as executive director. In 1954, Mr. Castellucci organized the Veterans' Home-Town Care Plan which permits veterans a free choice of doctors when receiving medical care.

Dr. Stuart Sessoms, who has been a member of the general medicine branch of the National Cancer Institute, has been named to the medical staff of the director of the Clinical Center, National Institutes of Health, Bethesda, Md. In his new assignment, Dr. Sessoms will serve as medical officer for the centralized admission and follow-up services, and as liaison between the institutes' clinical research programs and the patient care services provided by the clinical center.


Artemas C. Leslie

Artemas C. Leslie, insurance commissioner of Pennsylvania, has been named associate director of the Blue Cross Commission in charge of the newly established Blue Cross office in Washington, D.C. Mr. Leslie has been

active in the affairs of the National Association of Insurance Commissioners. He has been a member of the association's executive committee and chairman of the subcommittee on Blue Cross and Blue Shield for the accident and health committee.

Dr. Clifton K. Himmelsbach, who has been assistant chief of the division of hospitals, U.S. Public Health Service, Washington, D.C., since 1953, has been named chief of the division. Before going to Washington in 1947 as chief of the medical operations branch of the Federal Employe Health Program, Dr. Himmelsbach was medical consultant for the office of vocational rehabilitation, serving in Kansas City, Mo., and Chicago.

Dr. Alex M. Burgess, F.A.C.P., has resigned as area chief of medicine of the Veterans Administration, Washington, D.C., and has been appointed director of medical education at Newport Hospital, Newport, and Miriam Hospital, Providence, both in Rhode Island.

Dr. Robert H. Lowe, formerly administrator of Rochester General Hospital, Rochester, N.Y., has been named staff representative for the Council on Medical Education and Hospitals of the American Medical Association, Chicago, and will also serve as field representative for the Joint Commission on the Accreditation of Hospitals for the states of Ohio, Michigan and West Virginia.

Deaths

W. John Dobyns, director of Tacoma General Hospital, Tacoma, Wash., died recently at the age of 43. Mr. Dobyns was a trustee of the Washington State Hospital Association and during the last year had been instrumental in the establishment of a Washington state chapter of the American Association of Hospital Accountants. Previous to his affiliation with General Hospital, Mr. Dobyns had been manager of Doctor's Hospital in Tacoma.

Clarence Connelly, administrator of Community Memorial General Hospital, La Grange, Ill., died recently. Mr. Connelly was formerly administrator of University Hospital, Loyola University, Chicago, and at one time was associated with Booz, Allen and Hamilton, management consultants, Chicago. Before going to La Grange Mr. Connelly had been registrar of Veterans Administration Hospital, Hines, Ill.

Sister M. Domitilla, superintendent of St. Mary's Hospital, Rochester, Minn., from 1939 to 1949, died recently at the age of 65. Since 1949 Sister Domitilla had been hospital consultant and religious supervisor at St. Mary's Hospital.

William Bingham II, philanthropist who established the Bingham Associates Fund, died recently at the age of 75. Interested in developing better medical care throughout New England, Mr. Bingham organized the fund in 1932, a regional program which brings the facilities of urban hospitals to local hospitals. About 40 hospitals are affiliated with the fund which is centered at the New England Center Hospital, Boston, a unit of the New England Medical Center. Mr. Bingham was responsible for the construction of Joseph H. Pratt Diagnostic Hospital and Farnsworth Surgical Wing at the New England center. He also provided endowment funds and buildings for many medical and educational institutions in New England and other parts of the country.

Elmina Wood, former superintendent of nurses of Eastern Long Island Hospital, Greenport, N.Y., died last month.

At the patient's bedside
In staff cafeterias
In the hospitality shop
— the all-around dinnerware is MELMAC®

Melmac dinnerware is so dependably break-resistant—seldom needs replacement

. . . it washes hygienically clean, by hand or by machine

. . . its beautiful colors and lustrous finish make foods look temptingly good

. . . it's so light in weight that nurses, kitchen help—all who handle it appreciate its deceptive lightness

. . . it stacks quietly—a big contribution to the hush-hush atmosphere that helps speed patients' recovery

More and more hospitals are using more and more dinnerware made of Melmac molding material!

Investigate Melmac dinnerware and the significant role it can play in *your* hospital. Ask your supplier for full information and samples —or write us for the illustrated booklet, "Of Melmac Dinnerware."

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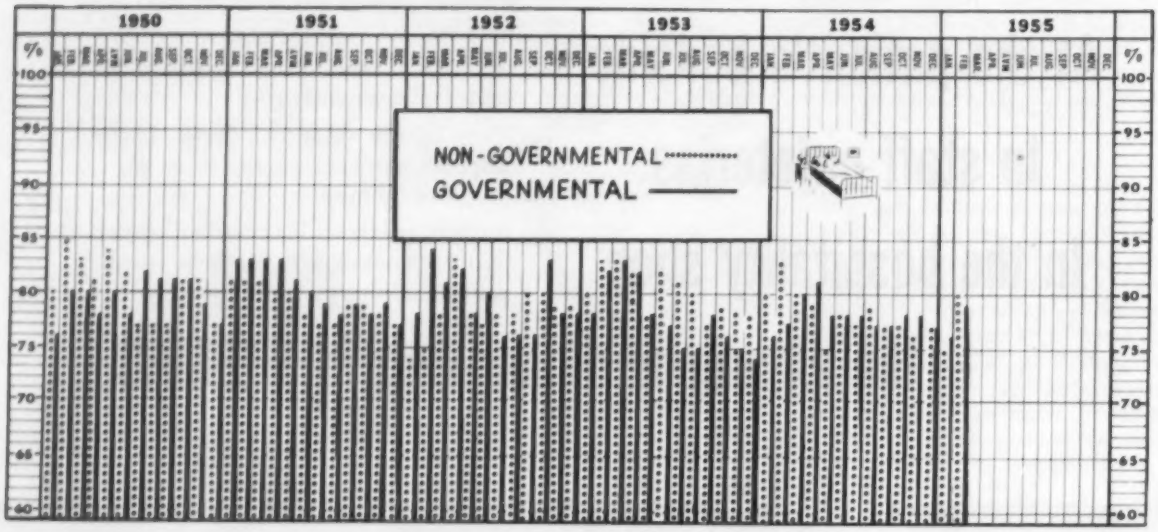
60 Projects Reported for Period Ending March 7



Occupancy of voluntary hospitals reporting for the month of February was 80.1 per cent of capacity, starting the seasonal climb from January's 78.5 per cent. Government hospitals reported 79 per cent occupancy—the same as the occupancy reported for the previous month.

New construction reported for the period ending March 7 totaled $57,586,510, compared to $87,383,242 for the corresponding period a year ago. For the year to date, the total is $98,234,120 this year, compared to $106,966,732 in 1954. In the current period, there were 60 projects—14 new hospitals, 43 additions, two remodeling jobs and one nurses' residence.

Kenrubber floors **quiet** busy feet

Here is flooring so lastingly resilient you'd think coiled steel springs were imbedded in each tile! That's how KenRubber Floors cushion every footfall, hush the din of constant traffic in rooms and corridors and help reduce fatigue for all who walk. KenRubber's pre-polished surface resists dirt and stain...crisper, clearer, tile-deep colors stay fresh, and sparkling clean with minimum maintenance effort and expense. Wherever durable long-wearing floors are needed...KenRubber offers these *extra* advantages no other floor can equal. For further information contact your Kentile, Inc. Flooring Contractor.

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. . . More and More Hospitals *Adopt* Aloe Contour Breast Pads

Late last fall, the Aloe Company introduced an entirely new shaped, absorbent breast pad. Now hundreds of hospitals in all parts of the country have adopted as routine this better way of handling the problem of excess lactation.

The experience of Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska, is an example of the acceptance of this remarkably successful product. Mr. Francis Bath, Business Manager, writes:

". . . We believe that St. Joseph's was one of the earliest of the hospitals to use this breast pad in the maternity department, where it has won favor not only with the personnel, but even more among the patients. We have had several mothers who have taken home as many as six boxes . . !!

"Sister Mary Corneliana, O.S.F., O.B. Supervisor, is enthusiastic about the pad, as she finds it much more satisfactory than the sponges which were used formerly."

This shaped pad was one of those ideas the need for which had been felt for a hundred years or more, but about which little was done. Nurses and supervisors have always known that there must be a better way of stemming the flow of excess lactation in new mothers than that of using irritating gauze sponges, make-shift cut pads or lumps of cotton under the bra.

It takes hours of hospital personnel time to "manufacture" such improvised pads, and additional labor time to apply, with the results seldom satisfactory. Hospitals speedily recognized the obvious advantages of a prepared, scientifically designed pad, when we introduced it.

Aloe Takes No Credit for suggesting the shaped Breast Pad. Actually a physician friend of the Company decided that the time for such a pad was long overdue. Nature and common sense dictated the design. We merely placed the problem of production before an experienced manufacturer, with the stipulation that materials must be of the finest and that control of quality must be rigid.

The Natural Contour Shape and perfect absorbency of Aloe Contour Breast Pads are responsible for their instant acceptance. Anatomically formed to fit the breast with full coverage of nipple, areola and a generous adjacent area (3¾ inches in diameter), they are unobtrusive in appearance and afford complete protection to the patients' clothing. Patients, of course, overwhelmingly endorse them.

The Pads are made of cotton, filled with soft, highly absorbent cellulose —non-allergenic, non-irritating, helpful in preventing retracted and cracked nipples; a great aid in applying medication. They are packaged one dozen (average daily supply per mother) in an attractive carton; easy to dispense; labor saving; generally applied by the mother herself. Easy to store. They are disposable and therefore eliminate repeat sterilization. Patients usually want to purchase an extra supply from the hospital dispensary for continued use at home.

Among Aloe Contour Breast Pad users are:

Ball Memorial Hospital
Muncie, Indiana

Centro Asturiano Hospital
Tampa, Florida

Creighton Memorial St. Joseph's Hospital
Omaha, Nebraska

Good Samaritan Hospital
Sandusky, Ohio

Hutchins Memorial Hospital
Buford, Georgia

Lee Memorial Hospital
Fort Myers, Florida

Marymount Hospital, Garfield Heights, Ohio

McLaren General Hospital
Flint, Michigan

Mease Hospital, Dunedin, Florida

Mercy Hospital, Toledo, Ohio

Misericordia Hospital
Milwaukee, Wisconsin

Munroe Memorial Hospital
Ocala, Florida

Ohio Valley General Hospital
Wheeling, West Virginia

Passavant Memorial Hospital
Jacksonville, Illinois

Roper Hospital
Charleston, South Carolina

Self Memorial Hospital
Greenwood, South Carolina

South Carolina Baptist Hospital
Columbia, South Carolina

St. Anthony's Hospital
St. Louis, Missouri

St. Joseph's Hospital, Milwaukee, Wisconsin

St. Joseph's Mercy Hospital
Pontiac, Michigan

St. Luke's Hospital
Kansas City, Missouri

St. Mary's Hospital, Athens, Georgia

St. Mary's Hospital
Kansas City, Missouri

Tallahassee Memorial Hospital
Tallahassee, Florida

Tampa Municipal Hospital
Tampa, Florida

The Valley Hospital, West Point, Georgia

University of Kansas Medical Center
Kansas City, Kansas

Winter Haven Hospital
Winter Haven, Florida

If you have not seen the Pad, just jot your name on your hospital letterhead today. Sample and literature will be sent immediately.

A. S. ALOE COMPANY

AND SUBSIDIARIES

1831 Olive Street St. Louis 3, Mo.

LOS ANGELES • SAN FRANCISCO • SEATTLE • MINNEAPOLIS • KANSAS CITY • DALLAS
NEW ORLEANS • ATLANTA • WASHINGTON, D. C.

Now! Harvest New Profits with a

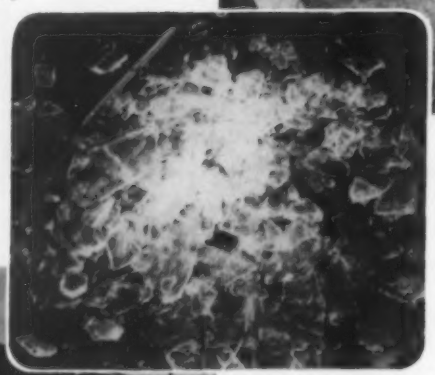
TRADE FRICK MARK®

SHELL-ICE MAKER

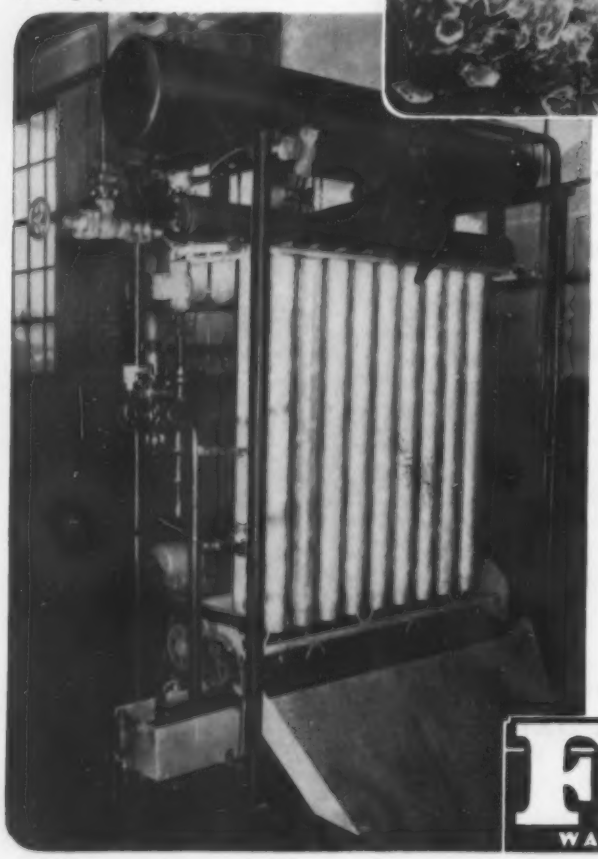
(Patents Applied For)

At Right: You get sized ice quickly, and with important savings, using this revolutionary equipment. Photo compares average pieces of Shell-Ice to size of a pencil.

Below: Complete machine of 5 tons capacity, ready for connection to refrigerating system.



Water flows down outside of tubes, providing agitation necessary for freezing into hard, clear ice. Thawed and fragmented by warm gas, ice ¼" thick can be harvested *automatically* every 10 minutes. Curved shell-like ice gives maximum cooling.



Ideal for dairies, fisheries, poultry and vegetable packing houses, hotels, restaurants, institutions and industrial plants—wherever sized ice is needed.

Shell-Ice is frozen on polished vertical tubes by direct-expansion ammonia or Freon, in thicknesses of ⅛ to ½ inch, and is broken by spinners into odd-sized pieces as small as wanted. No snow, scrapings or waste, and no special cleaning required. Shell-Ice is dry and solid, and with average good water is clear.

The Shell-Ice Maker is quick-acting, highly efficient, automatic and economical. All-steel construction, no delicate parts. Scale does not collect on freezing surfaces. Built in 12 standard sizes, ½ to 30 tons ice-making capacity each. Requires very small floor space: no big liquid receivers or other auxiliaries needed. Dozens already in satisfactory service.

Get the whole story: ask for Frick Bulletin 54.

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TERMS: 20c a word—minimum charge of $4.00 regardless of discounts—No charge for "key" number.
Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR—33; married; B.S.; C.H.A.; 3 years administrator 50 to 60 beds, general; all purchasing; active personnel, public community and hospital relations; including radio; consider hospital to approximately 100 beds or assistant larger hospital. MW 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—37, M.S. Hospital Administration; now completing residency in 1000-bed general university hospital desires position as administrator or assistant. Reply MW 78, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Mature, male, supervisory medical technologist; A.S.C.P.; some x-ray; A.B. degree; 15 years experience in hospitals including army hospital; references, lay and medical. Apply MW 79 The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PATHOLOGIST—Certified clinical and anatomic pathology; age 38; category IV; associate professor; extensive surgical pathology, teaching, research, publications; desire hospital appointment; prefer academic and research possibilities. Apply MW 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

RADIOLOGIST—32; category IV, certified, diagnosis and therapy; 2 years assistant professor radiology associated with large teaching hospital, desires hospital department directorship. Reply MW 70, The Modern Hospital, 919 N. Michigan Avenue, Chicago, 11.

The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Medical degree, Harvard; three years' teaching (medicine); two years, assistant director, teaching hospital; fourteen years, administrator, voluntary general hospital, 400 beds.

ADMINISTRATOR—Master's, business administration; five years, associate director, university hospital, 800-beds; seven years, director 400-bed teaching hospital; FACHA.

ADMINISTRATOR—B.S. Nursing Education; M.P.H. Hospital Administration; three years, director of nursing, 200-bed hospital before specializing; four years, administrator, small general hospital.

ADMINISTRATOR—Assistantship preferred; B.A., Business Administration; M.S., Hospital Administration, Columbia; three years, hospital accountant before taking course.

ANESTHESIOLOGIST—Diplomate; Fellow, American College of Anesthesiologists; successful private practice since 1949; interested in re-locating to obtain better educational advantages for children.

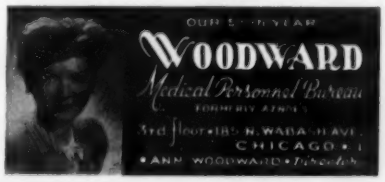
DIRECTOR OF NURSING—B.S., B.N., M.A., degrees; five years, director of nursing, 200-bed hospital; four years, assistant dean and assistant professor, university school.

MEDICAL BUREAU—*Continued*

PATHOLOGIST—Diplomate; FACP; eight years, director of pathology, 350-bed general hospital, consultant to several others.

PHYSIATRIST—three-year fellowship, teaching center; two years, charge department, army hospital; Diplomate, Physical Medicine and Rehabilitation.

RADIOLOGIST—Diplomate, American Board; three-year residency, teaching center; four years, associate radiologist, 500-bed hospital; would like own department.



ADMINISTRATOR—2 years, assistant director, 2 years, acting director, university hospital, nominee, ACHA; early 30's; one of finest younger men in the hospital administrative field.

ADMINISTRATOR—M.H.A. several years, hospital administrative residency, university hospital; 4 years, administrator 130-bed general hospital; member, ACHA.

ADMINISTRATOR—Medical; Degree, leading school; 4 years, medical director, university hospital; 6 years, faculty member, medicine before assuming administrative duties; middle 40's.

ADMINISTRATOR—Male registered nurse; 36; B.S., Psychiatric Nursing; M.P.H., Hospital Administration, University of Pittsburgh; administrative residency, large southern hospital; 6 years experience staff and supervisory nursing before specializing; southeast only.

ADMINISTRATOR—Woman registered nurse; 48; B.S., Nursing Administration; M.P.H., Hospital Administration, Yale; administrative residency, important 400-bed hospital center; 12 years as instructor and educational director, 200-bed voluntary general hospital; seeks directorship or assistantship, 100 mile radius New York City; nominee, ACHA; 3 years administrative experience.

ADMINISTRATOR—38; B.A. Harvard; M.P.H. Michigan; Doctorate, Public Administration; past 6 years secretary, health and hospital division, important council; duties involved community planning, development of medical care, hospitals and public health services; primary interest, medical care administration; secondary, hospital planning.

ADMINISTRATIVE ASSISTANT—27, B.S., Accounting; M.H.A.; several years administrative residency, 350-bed general hospital.

ANESTHETIST—Registered; 50's; 13 years anesthesia experience; seeks 8 hour shift, OB anesthesia only; Alabama, Georgia, Mississippi, Louisiana.

COMPTROLLER—10 years accounting experience including 2 years, instructor, accounting and 6 years, public accountant; member, National Association Cost Accounting.

(Continued on page 192)

WOODWARD—*Continued*

DERMATOLOGIST—31; M. S., D & S; Diplomate, 2 years, chief, D & S, large army hospital and consultant, D & S, Korea; currently private practice, D & S with Board dermatology; seeks hospital appointment preferably with part-time teaching; southeast or southwest.

DIRECTOR OF NURSES—B.S., Nursing Education, Boston University; 4 years, nursing arts instructor, educational director, 150-bed voluntary general hospital; 1½ years, director of nursing, large southern hospital; seeks position as director of nurses and educational director; large hospital, northeast only; late 30's.

EDUCATIONAL DIRECTOR—B.S., Nursing, Boston College; M.S., Public Relations, Boston University; 7 years supervisory experience; preferably assistant educational director; New England and California; 30's.

MEDICAL RECORD LIBRARIAN—Registered; early 20's; graduate, approved MRL school; 6 months experience, 4 as assistant, 200-bed university hospital; seeks assistantship or chief position, university affiliated hospital; New England only.

PATHOLOGIST—33; Diplomate, pathology, anatomy and clinical pathology; past year, direct department pathology, 300-bed hospital; seeks connection anywhere on Gulf of Mexico or California.

PEDIATRIC NURSE—M.A., Nursing Education, Columbia; 1 year, pediatric supervisor and instructor, 500-bed general hospital; 3½ years assistant professor nursing in pediatrics, college affiliation important university hospital, east; prefer pediatric teaching appointment, college program; midwest and east; age 30.

RADIOLOGIST—Ph. M. Physics; Diplomate, radiology, also certified, radiological physicist; certificate pending in medical neuclear physics; will be one of very few so distinguished; early 40's.

X-RAY TECHNICIAN—Male; ARXT; age 28; 2 years x-ray technician, 100-bed general hospital; 20 months experience, chief x-ray technician, 100-bed voluntary general hospital; x-ray training received Johns Hopkins; Washington state only.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

MEDICAL RECORD LIBRARIAN—Registered; 15 years experience; west or southwest; large hospital preferred.

EXECUTIVE HOUSEKEEPER—2 years college; attended institutes in housekeeping; 3 years assistant, Michael Reese Hospital, Chicago; successful experience.

ASSISTANT ADMINISTRATOR—M.S. Degree, mid-western university; 2 years personnel director, large western hospital; any locality considered.

BUSINESS MANAGER—B.A. Degree, Hotel Administration; 7 years assistant business executive; will consider assistantship in 300-500 bed hospital.

classified advertising

POSITIONS WANTED

INTERSTATE *Continued*

ADMINISTRATOR — M.S. Degree, Hospital Administration; 4 years experience, executive director, mid-western welfare bureau; 3 years administrator 100-bed hospital; desires change.

COMPTROLLER—Age, 34 years; Degree, Accounting; 5 years banking experience; past 6 years comptroller and administrative assistant, 150-bed eastern hospital.

NURSE ADMINISTRATOR—Age, 45; 2 years college; 5 years director, nursing service, 150-bed hospital, New York; 12 years administrator 75-bed hospital; will consider reorganizational assignment; available.

POSITIONS OPEN

ANESTHETIST—Registered nurse; New 250-bed, well equipped general hospital; department directed by medical anesthesiologist, cooperative medical staff and personnel; good personnel policies; salary depends on experience, minimum $414.00 with periodic merit raises. Apply, Director, McLaren General Hospital, 401 Ballenger Highway, Flint 2, Michigan.

ANESTHETIST—Nurse; for an old established group; good starting salary and permanent position. Apply The Sugg Clinic, Ada, Oklahoma.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

ANESTHETIST — Nurse; 300-bed approved hospital in Detroit area; salary $400 per month, time and a half for overtime, double time for Sundays and holidays; 13 sick days yearly. Apply I. D. Nickerson, M.D., Anesthesia Department, Highland Park General Hospital, Highland Park 3, Michigan.

ANESTHETISTS—Nurse; (2); new 225-bed general hospital; medium size town 60 miles east of Pittsburgh; excellent working conditions and personnel policies; very good starting salary. Apply Robert L. Seifert, Personnel Director, Mercy Hospital, Johnstown, Pennsylvania.

ANESTHETISTS—3 nurse anesthetists to increase staff; approved A.A.N.A. training school; good working conditions; medical anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

ANESTHETIST—Nurse; male or female; 75-bed hospital associated with group; modern equipment; salary $500.00 per month; paid vacation, holidays, sick leave policy; college town of 8000. Apply, Bashline Hospital, Grove City, Pennsylvania.

ANESTHETIST—Nurse; Registered or eligible for registraiton; under supervision of anesthesiologists in 200, enlarging to 300-bed hospital; customary personnel policies; salary open. Apply Brackenridge Hospital, Austin, Texas.

ANESTHETIST—Nurse; wanted in 200-bed approved hospital for obstetrical department; 40-hour week and fringe benefits. Apply Personnel, St. Elizabeth Hosiptal, Appleton, Wisconsin.

DIETITIAN—Chief; Challenging position in 350-bed general medical and surgical hospital in Philadelphia; large proportion therapeutic diets; in charge of over-all administration of department; 6 qualified assistant dietitians; approved hospital, no school of nursing; applicant must be A.D.A.; age 35-50, at least 10 years experience; starting salary $6500; 5 day week; Social Security; fringe benefiits. Apply to MO 99, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

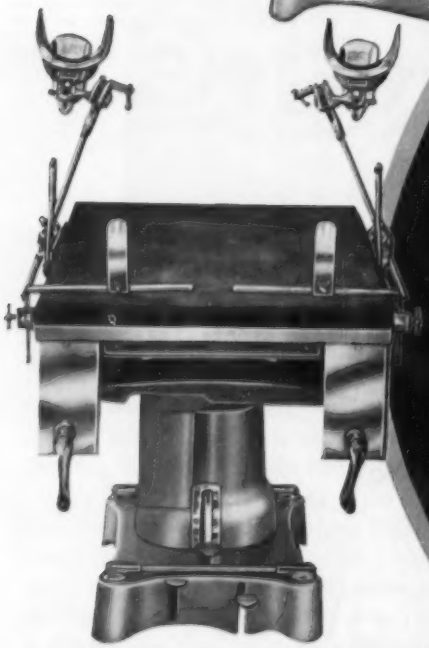
DIETITIANS—Two; plan special diets; instructs patients; checks trays; some teaching of student nurses; salary start $300; 2 weeks vacation; 6 holidays; social security; we pay for hospitalization insurance and life insurance; free medical services; sick leave; retirement plan; 44 hour week now, will be 40 hour week as soon as staff adequate. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

DIETITIAN—Full charge ADA for 135-bed hospital fully approved. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

(Continued on page 194)

For Speed and Efficiency...
For Simplified O. B. Procedure

SHAMPAINE
HAMPTON
O. B. TABLE



The Shampaine Hampton offers superior advantages for the physician, nurse, all persons involved in O.B. procedure.

* **NEW CRUTCH SOCKET**

Permits easy, rapid crutch adjustment — lateral, radial and vertical — with one lever. Saves time and labor.

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All controls conveniently located at head-end for speed and efficiency.

- * One crank changes table from labor position to delivery position.
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Address.....

City..... Zone..... State.....

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POSITIONS OPEN

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Assistant to chief; general hospital for men, women and children; duties involve therapeutic diet planning, patient contact, assist in general supervising and some tray checking. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Administrative; A.D.A. Member; 200-bed pediatric hospital with specialized teaching program for student nurses, and allied medical professions; expanding facilities provide excellent opportunity for advancement. Apply Personnel Department, Children's Hospital, Columbus, Ohio.

DIETITIAN—Chief; ADA member, 306-bed hospital with large clinic and full-time medical staff of 32; good salary and good personnel policies. Apply Administrator, Geisinger Memorial Hospital, Danville, Pennsylvania.

DIETITIAN—Chief therapeutic; duties for 650-bed hospital in Texas Medical Center; salary open. Apply, Director of Dietitics, Hermann Hospital, Houston 25, Texas.

INSTRUCTOR — Medical and surgical; new 240-bed hospital with school of 80 students; national temporary accreditation; college affiliation for students; B.S. degree required, salary open, commensurate with education and experience, liberal personnel policies. Apply to Associate Director, School of Nursing, Fairview Park Hospital, Cleveland, Ohio.

INSTRUCTOR — Nursing arts; new 240-bed hospital with school of 80 students; national temporary accreditation; college affiliation for students; B.S. degree required, salary open, commensurate with education and experience, liberal personnel policies. Apply to Associate Director, School of Nursing, Fairview Park Hospital, Cleveland, Ohio.

INSTRUCTORS—Two; medical and surgical; opening for nursing arts instructors with B.S. degree; four weeks paid vacation; salary open. Apply Methodist Hospital, Gary, Indiana.

MISCELLANEOUS—Director of Nurses and Clinical Supervisor; for 100-bed general hospital with school of nursing; located in beautiful section of southwest Virginia; excellent salary; private apartment. Apply Administrator, Pulaski Hospital, Inc., Pulaski, Virginia.

NURSES—General duty; all services, 320-bed hospital; unhappy with the snow? Come to sunny Arizona, home of the Grand Canyon; watch movies being made in Sedona; only 185 miles south is romantic Mexico; minimum starting salaries, $245 evenings, $240 nights or rotation, $230 days; 40-hour, five day week, merit raises every six months for three years, paid vacation, sick leave and holidays, Blue Cross available, social security. Write Director of Nursing, Good Samaritan Hospital, Phoenix, Arizona.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES — Registered; 2 for general duty nursing in 36-bed hospital located 72 miles from Sun Valley, Idaho; 40 hour work week, 2 weeks paid vacation per year, extra pay for holidays and overtime; meals furnished while on duty; we will assist in locating living quarters near hospital. Apply Mrs. Maude L. Summerville, R.N., Superintendent, Gooding County Memorial Hospital, Gooding, Idaho.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

(Continued on page 196)

Plagued by door-swing? Modernfold cures it!

If your hospital or clinic is plagued by that chronic ailment, old-fashioned door swing, it's time for MODERNFOLD doors.

By installing MODERNFOLD—the folding door that opens and closes completely *within* the door frame, you gain floor space at every opening which door swing formerly wasted. As a space divider in wards and other areas where the need for space changes quickly, MODERNFOLD is particularly valuable. Private rooms can be converted into semi-private quarters—in seconds! MODERNFOLD moves into place on overhead tracks—or folds back—providing exactly the kind of space you require at any time.

The double-strength steel framework is covered by long-wearing vinyl. MODERNOFLD doors are easily washable and come in scores of cheery colors.

For more efficient use of space and elimination of door swing, MODERNFOLD doors are a panacea.

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DOORS

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POSITIONS OPEN

NURSES—Operating room; at Medical Center; start $270; increases at 6 months, 1 year and 2 years; overtime premium pay; paid vacation; 6 paid holidays; sick leave; social security; we pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester Minnesota.

NURSES — Operating room; immediate appointments; 511-bed newly enlarged and finely equipped hospital; ten operating rooms now completed; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial and educational friendly activities; living cost reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly and considerate working associates and conditions; progressively advanced personnel policies; starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES—Registered; two, for 50-bed tuberculosis hospital in Indiana college town; Excellent salary and working conditions; Complete maintenance, liberal vacation and sick leave. Apply Superintendent, Smith-Esteb Hospital, Richmond, Indiana.

NURSES—Registered staff; immediate appointments; 511-bed newly enlarged and finely equipped general hospital; duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial, and educational friendly activities; living costs reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly, cooperative work relations and conditions; progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES—Registered; for operating room and general floor duty. Apply, Wooster Community Hospital, Wooster, Ohio.

NURSES—Graduate registered staff; in-service education; liberal personnel policies; rotating shifts; starting salary $300. Apply Nursing Supervisor, Polio Center, 1801 Buffalo Drive, Houston 3, Texas.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES—Registered; salary $160.00 per month with full maintenance; eight hour rotating shifts with one day off each week and one extra day every second week; eight legal holidays, vacation and sick allowance each one and one-half days monthly; complete new unit under construction. Apply Superintendent, Lady Minto Hospital, Cochrane, Ontario, Canada.

PATHOLOGIST — To head department; approved hospital in Pennsylvania. Address reply to MO 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

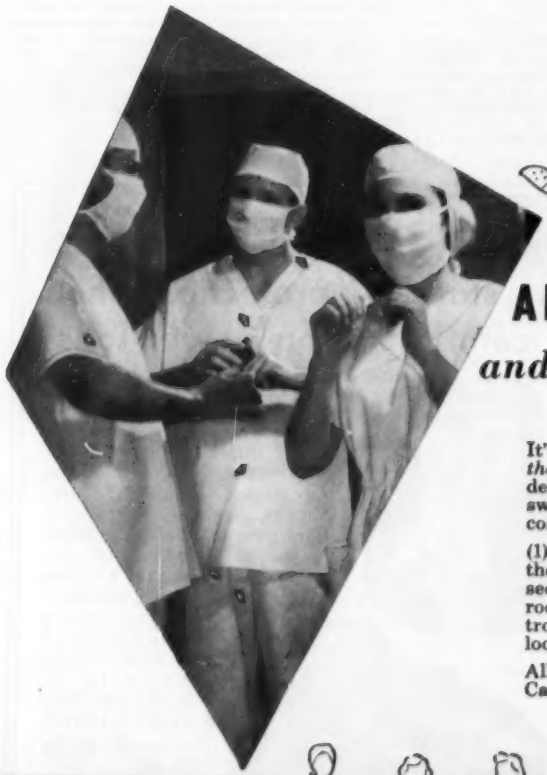
PHYSICIAN & SURGEON—M.D.; wanted by the city of Umatilla and its trading area with a population of about 6000; new 17-bed hospital with delivery room, surgery nursery, x-ray, and laboratory; no resident doctor in Umatilla, field wide open; for further information, apply Carl Morrison, Administrator, Umatilla Hospital District No. 1, Umatilla, Oregon.

PSYCHIATRIST—Certified; to act in the position of associate physician at a private psychiatric hospital; salary open. Apply MO 100, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 198)

to Mr. Purchasing Agent

FOR THE COURAGE TO CHANGE... FOR THE BETTER!



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ANGELICA SCRUB GARMENTS-

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It's a wise Purchasing Agent who weighs all the evidence and *then* makes the decision to change his old buying habits without delay. Hundreds of Purchasing Agents are doing just that — switching to Angelica Scrub Garments and cutting replacement costs. Look at these features:

(1) "Task-tested", exclusive Armor* Cloth . . . or Monte* Cloth, the fabric that lasts as much as 25% longer. (2) All strain points securely bar-tacked against costly tears. (3) Re-inforced V-neck, roomy, easy on and off. (4) Full-cut armholes. (5) Self material trouser drawstring permanently attached to prevent working loose. (6) Full, roomy crotch.

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Complete Line of Uniforms for:
DIETARY
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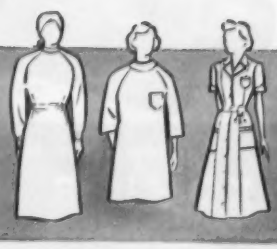

Angelica®
UNIFORMS

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POSITIONS OPEN

PURCHASING AGENT—220-bed hospital; located large city, Pacific northwest; male, married; age 30-45; minimum 5 years hospital purchasing and storeroom experience; college education preferred; state salary expected. Apply MO 98, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SECRETARY-EXECUTIVE: Missouri State Nurses' Association; experience, organizational work and leadership ability desirable qualifications; salary commensurate to ability and experience. Write Board of Directors, Missouri State Nurses' Association, Box 325, Jefferson City, Missouri.

SUPERVISOR OF NURSES—For small general hospital in heart of dude ranch country; good personnel policies; experienced in small hospital, must know obstetrics and surgery; desire someone capable of administering anesthetics but not essential; salary depending on experience and qualifications; General Staff nurses needed for permanent and summer relief. Apply St. John's Hospital, Jackson, Wyoming.

SUPERVISOR—Hospital for convalescent orthopedic and medical children; 40-hour week; one month vacation and two weeks sick leave annually; B.S. preferred; salary dependent on qualifications. Apply Children's Convalescent Home, Cincinnati 19, Ohio.

SUPERVISOR — Obstetric; modern 115-bed hospital; administrative responsibility for 23 beds and 29 bassinets; approximately 1000 deliveries yearly; graduate staff; advance preparation and experience required. Write Director of Nursing, Mount Sinai Hospital, Hartford, Connecticut.

SUPERVISOR—Obstetrics; responsible for supervision of small unit and teaching program in obstetrics; California registration, academic degree and successful experience in obstetrics required; salary $365; forty-hour week, paid vacation and sick leave and Blue Cross hospitalization provided. Apply Director of Nursing, French Hosptial, San Francisco, California.

SUPERVISOR—Operating room; 54-bed general hospital, experience desirable, liberal personnel policies; salary commensurate with preparation and experience; increase in salary every 6 months for a period of 2 years. Contact Esther M. Squire, R.N., Administrator, Washington County Hospital, Washington, Iowa.

TECHNICIAN—Registered laboratory; single, white female; needed immediately; salary $250.00 per month with full maintenance. Apply Medical Director, Florida State Hospital, Arcadia, Florida.

TECHNICIAN—Registered laboratory; for 265-bed teaching hospital, located on Chicago's near-north side; modern laboratory; starting salary $290 month; alternate 5 and 6 day week; merit increases; excellent employee benefits including 4 weeks vacation; 12 days sick leave; laundry furnished and a 50% tuition reduction on courses at Northwestern University. Apply Passavant Memorial Hospital, 303 East Superior Street, Chicago 11, Illinois.

TECHNICIAN — Laboratory; A.S.C.P. registered; very modern hospital in popular resort area to take complete charge in completely equipped laboratory; excellent call arrangement, guaranteed $375 per month base salary; unusual opportunity for alert capable person; send photo and particulars to Schoolcraft Memorial Hospital, Manistique, Michigan.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS — (a) Director, general hospital, 400-beds affiliated university medical school; $10-$20,000 depending upon training, experience, whether medical or non-medical. (b) Director, large organization specializing in physical medicine rehabilitation; $5,000,000 expansion program; competent administrator with necessary cultural background to represent important institution required. (c) Medical; teaching hospital, 800-beds; extensive building program; leader of experience qualified to direct entire medical center re-

(Continued on page 200)

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

quired. (d) Assistant medical; new 500-bed teaching hospital; northwest. (e) Administrator to re-organize teaching hospital, coordinate hospital and medical school; considerable experience required. (f) Medical or non-medical to serve as consultant, voluntary organization, 500-beds; foreign assignment; three years; knowledge of Spanish or Portuguese required. (g) To succeed administrator retiring after 26 years' service; 100-bed hospital; university city, east. (h) Assistant, 500-bed general hospital, teaching institution; large city, medical center, east. (i) Clinic manager; staff of 27 specialists. MH4-1

ADMINISTRATORS — PROFESSIONAL NURSES: (a) Assistant administrator; voluntary general hospital, 350-beds; large city, medical center; Master's required. (b) New 50-bed Hill Burton hospital; small town, midwest. MH4-2

ANESTHETISTS—(a) Two; new general hospital, 200-beds; normally staff of 7 anesthetists; currently 5; residential town, near large city, medical center, midwest; $6000-$7000. (b) Small general hospital; resort town, Pacific northwest; minimum, $550. (c) Three; new 325-bed general hospital; California. (d) Two; 325-bed general hospital; outside United States; although tropical country, mild pleasant climate. (e) Anesthetist qualified to serve as director of nursing; new 50-bed hospital; anesthetics average 25-30 monthly; residential town near several large cities, southeast; $7200. MH4-3

COLLEGE, PUBLIC HEALTH, SOCIAL DIRECTORS—(a) College nurse; young women's college, east. (b) School nurse, direct program; suburban town; 10-month year; midwest. (c) Public health nurse to head program, 350-bed hospital, affiliated 24 man clinic; east. (d) Social director; new 700-bed hospital; fine facilities; collegiate school; east. MH4-4

DIRECTORS OF NURSING—(a) Dean, college of nursing to be established at university in connection with its new college of medicine; preferably one experienced in establishing new programs with distinct interest in new approaches to nursing education. (b) Director of nursing service and school and, also assistant director; 275-bed hospital, collegiate school; women with Master's degrees, experienced in collegiate program preferred; college town, northwest. (c) To succeed director retiring after long tenure; 250-bed general hospital; affiliated medical school; New England. (d) General 475-bed hospital; 170 students; all departments well staffed; interesting city outside continental United States; although tropical country, mild pleasant climate. (e) Small general hospital, school averages 22 students; Turkey. (f) One of the country's leading hospitals for children; 300-beds. (g) Nursing service, general hospital, 225-beds currently under construction; completion October; university city, south; key personnel now being selected. MH4-5

DIETITIANS—(a) Chief; 350-bed teaching hospital; staff of 6 assistants; $6500; university city, east. (b) Chief; voluntary general hospital, 450-beds increasing to 600 by September; department staff of 80; college town, midwest; $6000. (c) New general hospital, 100-beds; coastal town, Washington. (d) Chief; university hospital, 300-beds; plans completed for new medical center including hospital of considerably greater capacity. (e) Therapeutic dietitian; 200-bed hospital; department directed by food manager; college town, south; $6000. (f) Staff; new general hospital, 300-beds; airbase, California. MH4-6

EXECUTIVE HOUSEKEEPERS—(a) General 300-bed hospital affiliated with one of country's leading clinics; staff of 30 Board specialists; residential town near 2 medical schools; east. (b) New 100-bed hospital; Northern California. (c) University hospital now under construction, 450-beds; completion September; man preferred. MH4-7

(Continued on page 202)

PROTECTION OF LIFE BEGINS IN THE BOILER ROOM OF A HOSPITAL . . .

Here are 2 #584 125# Firebox Steam Boilers for gas or oil

Architect—F. O. Wolfenbarger & Associates, Manhattan, Kans.; Engineers—Howarth, Scott & Kinney, Kansas City, Mo.; Heating Contractor—Woodhull Plumbing Co., Manhattan, Kans.

KEWANEE

reserve plus rated boilers . . .

GUARANTEE EXTRA POWER TO MEET EMERGENCIES

When you think of protecting life in hospitals, you probably first think of spotless operating areas, sanitary rooms, fresh clean linen on gleaming white beds. And they're all important, too. But such safeguards would be for naught if power failed in the boiler room when emergency called. So, Architect F. O. Wolfenbarger and Engineers Howarth, Scott & Kinney made sure in planning for the Riley County Hospital, Manhattan, Kansas. Kewanee Reserve Plus Boilers were selected because they are certified to deliver 50% extra power, that measure of protection always "on call" no matter what the need. So, don't be misled by promises that a boiler delivers enough steam to meet average daily requirements. Be sure there is extra reserve to take care of unusual conditions. For that is when performance beyond the call of usual duty is a necessity. Kewanee Reserve Plus Rated Boilers guarantee that protection.

YOU can depend on KEWANEE engineering

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

EXECUTIVE PERSONNEL—(a) Chief admitting officer; 300-bed general hospital; university city, New York. (b) Chief accountant qualified to direct business office; 250-bed hospital currently under construction; completion October; key personnel now being selected; college town, south. (c) Food service manager; 250-bed hospital; staff includes therapeutic dietitian; coastal city, south. MH4-8

FACULTY POSTS—(a) Dean, program for graduate nurses only; preferably one with doctoral degree. (b) Chairman, university nursing education department; well qualified faculty; up to $9000. (c) Educational director and nursing arts instructor; new hospital; unexcelled working, living conditions; college town, North Carolina. (d) Pediatric, maternity and nursing arts instructors; beautiful modern hospital; general, 400-beds; 170 students, mostly Orientals; attractive city outside United States. (e) Clinical instructors in obstetrics, surgery, psychiatry; 600-bed teaching hospital on campus, medical school; large city, midwest. (f) Instructors, new collegiate program; California. (g) Public health instructor; liberal arts college; east. MH4-9

MEDICAL RECORD LIBRARIANS—(a) Chief; preferably one capable of planning a modern efficient department for growing teaching center; university hospital, 350-beds; plans completed for new medical center including 450-bed hospital, medical school, school of pharmacy. (b) Chief; qualified to reorganize department, 400-bed hospital; unit, university group; expansion program; medical center, east; attractive proposition. (c) Assistant; large general hospital; 40-hour week, all fringe benefits; residential and coastal town, California. MH4-10

STAFF & SURGICAL—(a) Teaching hospital; recently opened new wing; 400-beds; university center; opportunity continuing studies. (b) Staff; new general hospital, 100-beds; Alaska. (c) Staff and surgical; new hospital, 275-beds; airbase, California. MH4-11

SUPERVISORS—(a) Central service; new department, 250-bed general hospital; university town, east. (b) Outpatient; university hospital, 400-beds; university medical center, east. (c) Pediatric and obstetrical; general 250-bed hospital; resort city, Florida. (d) Operating room; new air conditioned department; 300 operations monthly; children's hospital; outstanding staff; medical center; minimum $5000. (e) All departments, new 350-bed hospital completion July; on campus medical school; south. (f) Floor and surgical; new 150-bed hospital; California. (g) Pediatric and obstetrical; Guatemala. (h) Teaching supervisors in public health and tuberculosis nursing; Panama. MH4-12

(Continued on page 204)

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

ADMINISTRATIVE EXECUTIVE POSTS—(a) Accountant; fully approved general hospital 275-beds; resort area, 100,000; northwest-central. (d) Business manager with experience in public relations; research institute; bay area; California. (f) Comptroller; general voluntary hospital large size affiliated university medical school; city of 120,000; east. (i) Office manager; well-staffed department; consider male or female; 100-bed voluntary general hospital; college town; northwest central. (j) Personnel director; important hospital, 300-beds; lovely college town 85,000; south. (n) Purchasing director; requires one with hospital experience; general hospital 300-beds; town 50,000; Canada.

ADMINISTRATORS—Women. (a) Lay or R.N., experienced in opening new hospital; 150-beds; about $7200; college town 30,000; south. (b) General hospital 100-beds attractive town 15,000; Pacific northwest.

DIETITIANS—(a) Chief; 90 employed in department; 300-bed teaching hospital; top salary; university medical center; midwest. (b) Chief; staff of 50; voluntary general hospital 200-beds; Boston area. (f) Assistant; industrial firm; about 2000 meals served daily; excellent personnel policies; large city; east.

WOODWARD—*Continued*

DIRECTOR OF NURSES—(a) Nursing service and education; fully approved 250-bed general hospital; to $6000, full maintenance; university medical center; midwest. (e) Nursing service and education; very large university hospital; resort and university city; southwest. (e) Nursing service; college affiliated school; to $5400; university town; south-central. (f) Nursing service and education; 200-bed voluntary general hospital; to $6000; east. (h) Nursing service; general hospital 200-beds; to $6000; attractive college town; midwest.

EXECUTIVE HOUSEKEEPERS—(a) Prefer male; 450-bed university medical center hospital opening soon; large university city; southwest. (b) 300-bed pediatric and maternity hospital; university affiliation; desirable large city; east. (e) Large university hospital; Pacific northwest.

FACULTY POSTS—(a) Educational director; large school; 500-bed teaching hospital; to $6600; east. (c) Dean, college school of nursing; prefer Ph.D.; large city; Pacific northwest. (d) Instructor in pediatrics or obstetrics; 26 month collegiate nursing program; to $4800 for 10 months; resort town 35,000; middle east. (e) Science instructor; 30 students; voluntary general hospital; town 15,000; east.

(Continued on page 206)

WOODWARD—*Continued*

SUPERVISORS—(a) Supervisory RN's., group studying long range effects atomic radiation; Japan. (b) Operating room, pediatric and obstetric; new hospital opening soon; resort town 30,000; southwest. (c) Obstetrical; 65 bed unit; college affiliated school, 100 students; large general hospital; east. (d) Operating room; 500-bed university hospital; desirable city; south.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 275-bed hospital, south central state; Medical Center; $10,000-$15,000. (b) 200-bed hospital, southeast. (c) 50-bed Iowa hospital. (d) Small Pennsylvania hospital. (e) R.N. Rehabilitation Center, east; 50-bed hospital. (f) R.N. 36-bed hospital, west.

OFFICE MANAGER—(a) Accounting Degree; 350-bed Ohio hospital. (b) 150-bed hospital, New York State. (c) Purchasing Agent; 300-bed Michigan hospital.

DIRECTOR, SCHOOL OF NURSING—(a) 300-bed hospital, mid-west; $6000, maintenance. (b) 250-bed hospital, Ohio. (c) 175-bed hospital, eastern Pennsylvania.

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POSITIONS OPEN

INTERSTATE—*Continued*

DIRECTORS, NURSING SERVICE—$4,500-$6,000.

INSTRUCTORS—Pediatric Nursing; public health; collegiate schools of nursing. $4800.

CHIEF LABORATORY TECHNICIAN—(a) 100-bed Michigan hospital; $350-$400. (b) 175-bed hospital, Ohio. (c) Laboratory and X-ray; southwest; to $350.

EXECUTIVE HOUSEKEEPER—(a) 225-bed hospital, Pennsylvania. (b) 275-bed hospital, Connecticut; to $400. (c) New 200-bed hospital, mid-west. (d) 155-bed hospital, California. (e) 175-bed Ohio hospital.

RECORD LIBRARIAN—(a) 300-bed Ohio hospital. (b) 175-bed hospital, suburb Philadelphia. (c) 250-bed hospital, west. (d) Michigan; 275-bed hospital.

PHARMACIST—200-bed hospital, east; $450.

ANESTHETISTS—Attractive locations; $500, up.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

55 East Washington Street

Chicago 2, Illinois

ADMINISTRATORS—(a) Southeast; 200-bed hospital; 325 employees; require hospital administrator training, plus practical experience; $10,000. (b) Assistant Administrator; south; Degree in Hospital Administration; 175-bed hospital located in large southern city; $5000 minimum to start. (c) Pacific northwest; 90-bed hospital, new and modern; require someone with experience in hospital of comparable size. (d) 400-bed hospital affiliated with school of medicine of large university; require good administrative background; $10,000 minimum. (e) East; 100-bed hospital, fully approved; located in city of 90,000; require good supervisory experience plus at least one year as assistant administrator; incumbent is retiring after 25 years. (f) Middlewest; 200-bed hospital, new, modern; within commuting distance of Chicago; $10,000.

DIRECTOR OF HEALTH SERVICES—Small college; duties include usual services to college students and laboratory school students plus teaching one or two classes in health education; $6,000.

(Continued on page 208)

SHAY—*Continued*

BIOCHEMISTS—(a) Middle west; 200-bed hospital; Ph.D. or Masters degree required; $8,000; (b) east; 400-bed hospital affiliated with university; Ph.D. required; $7,200. (c) Middle west; supervise clinical laboratory; Ph.D. required. $8,000 to start.

SUPERINTENDENT OF NURSES—ANESTHETIST; 20-bed company hospital of large mining company, modern, air conditioned, fully approved; warm summers and mild winters; living quarters and meals can be had very reasonably; $6,000.

PLACEMENT BUREAUS

THE ABBOTT REFERENCE REGISTRY
Box 26, Hobart, Indiana

—a lifelong reference service to professional and technical personnel.

Because the Registry does not charge a fee for placement, employers feel added confidence in its service. Safeguard your references by establishing a permanent professional file. A respected supplement to every placement activity. Send for brochure.

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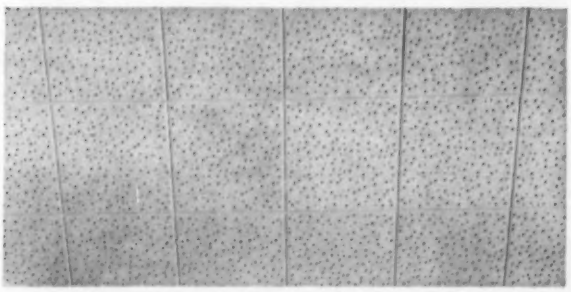
fire-safe Fiberglas Ceilings soak up noise!

Your dollar buys double value when you select ceilings of Fiberglas* Sound Control Products for your hospital. This most efficient sound-absorbing material soaks up as much as 75 per cent of unwanted noise—brings quiet into busy areas . . . and, in addition, effectively helps protect against the spread of fire.

Certified Fire-safe! Every Fiberglas Sound Control Product bears the Underwriters' Laboratories label, and is rated incombustible by the Acoustical Materials Association.



Random Perforated Acoustical Tile is one of the many attractive patterns in the full line of economical Fiberglas Sound Control Products.

Beautiful and Permanent! Extremely light and rigid, as well as moisture-resistant, Fiberglas Sound Control Products cannot shrink, sag or swell. Whatever style you select (there are many designs and colors to choose from) you are assured of lasting attractiveness.

Lowest in Cost! Yes, surprisingly enough these extra-value sound-absorbing ceilings are the lowest cost fire-safe ceilings you can buy.

Make your maintenance or construction budget go further. Install fire-safe, economical Fiberglas Ceiling Tile. For further information, send for your free copy of "The Medicinal Ceiling." It's full of helpful tips. Write: Owens-Corning Fiberglas Corporation, Dept. 78-D, Toledo 1, Ohio.

*Fiberglas, Sonofaced (Reg. U. S. Pat. Off.) Stria and Noise-Stop are trade-marks of Owens-Corning Fiberglas Corp.

OWENS-CORNING
FIBERGLAS
SOUND CONTROL PRODUCTS

- Textured, Perforated, Sonofaced*, Stria* Acoustical Tile
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Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

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Chas. J. Cotter, Director
(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.
(formerly Hagerstown, Maryland)

Information about
QUALIFIED NURSE PERSONNEL
is available from the
American Nurses' Association
PROFESSIONAL COUNSELING &
PLACEMENT SERVICE
37 So. Wabash Ave.
Chicago 3, Ill.
STate 2-8883

(Continued on page 210)

PLACEMENT BUREAUS

MEDICAL PLACEMENT SERVICE
Mrs. Stewart R. Roberts, Director

15 Peachtree Place, N. W.
Atlanta, Georgia

Southern Hospitals look to us for personnel.

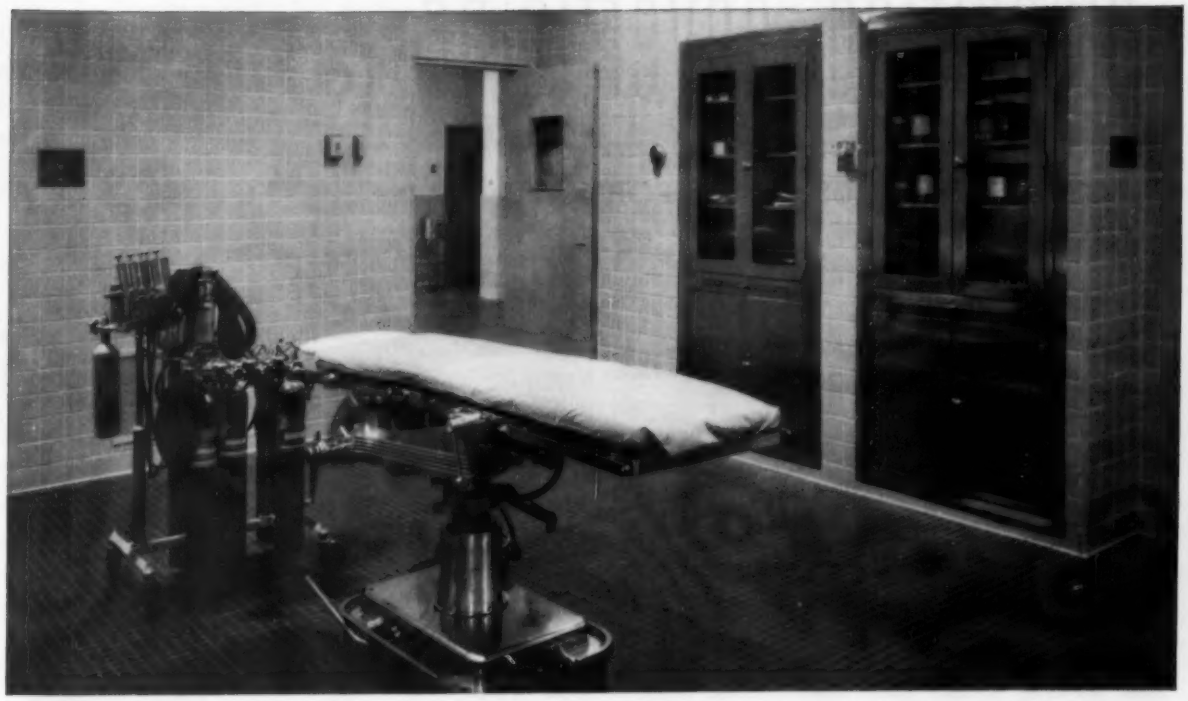
We have openings for Nurse Anesthetists, Laboratory Technicians, Nursing Directors, Dietitians. Let us help you locate the opportunity you are seeking.

INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.



Mosaic Impervious Electrically-Conductive Floor Tile, Pattern 1778-A3, and Mosaic glazed wall tile, color 302, Operating Room, Seton Hospital. Keuhne, Brooks and Barr Architects; Maguolo and Quick, Architects, Hospital Consultants. City Tile Co., Tile Contractor. Photos: Ulric Meisel.

Tested . . . accepted . . . approved for hospital surgical and anesthetizing areas

MOSAIC IMPERVIOUS ELECTRICALLY-CONDUCTIVE FLOOR TILE

In surgical and anesthetizing areas at Seton Hospital, Austin, Texas, this pre-tested, factory-warranted ceramic tile minimizes the danger of anesthesia explosion. It dissipates static electricity and prevents accumulation of electrostatic charges by providing moderate electrical conductivity for all personnel and equipment in electrical contact with the floor.

This permanent, sanitary floor tile meets all resistance limitations of May, 1954 NFPA Bulletin 56. Every tile is conductive and impervious to moisture, stain or insulating contamination. Easily maintained to highest standards of sanitation. And, its neutral warm brown color has a restful low light-reflecting factor. Mosaic manufactures glazed wall tile in a variety of sizes and colors which harmonize with conductive floor tile, including large 9″ x 6″ x ¼″ size tile. This material is ideal for attractive, permanently sanitary, easily maintained walls. Many other types of tile are available from Mosaic—the only complete line of ceramic tile.

Mosaic Impervious Electrically-Conductive Floor Tile and Mosaic glazed wall tile, Scrub-up Room, Seton Hospital.

For installation specifications and performance test reports, write Dept. 49-7, The Mosaic Tile Company, Zanesville, Ohio, for the "Mosaic Impervious Electrically-Conductive Floor Tile Factbook No. 196".

THE MOSAIC® TILE COMPANY

Member—Tile Council of America and The Producers' Council, Inc
Over 5000 Tile Contractors to serve you

America's largest ceramic tile manufacturer . . . offices, showrooms and warehouses from Coast to Coast.

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ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director

Suite 1004—79 West Monroe Street
Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

MISCELLANEOUS

CLINIC MEDICAL CENTER; Excellent location. Established. Fully equipped Surgery, X-ray, laboratory, treatment rooms, office. Rent or Lease all or part. No investment required. Sunset Medical Center, 1601 Griffith Park Blvd., Los Angeles 26, California. NOrmandy 1-4298, H. C. Hoppe, Director.

FOR SALE

6 Toastmaster Model 4DLC Portable Hot Food Trucks, Stainless Steel construction. Will hold 32 plates of food or 32 dozen rolls. Still in original crates. Robertshaw thermostat for 115 volts A.C. or D.C. operation. $300 each, f.o.b. Elmira, N.Y. Write Assistant Administrator, Arnot Ogden Memorial Hospital.

NURSING AND MEDICINE
We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

WILL LEASE OR SELL 30-BED HOSPITAL Fully equipped, new X-ray machine, complete with laundry and surgery, center of 35,000 drawing population. Selling to settle estate, $300,000 value. Sacrifice $75,000 including building. Will take back $50,000 mortgage, inventory list available. Write, Ralph J. Corio, Real Estate Broker, Philipsburg, Pennsylvania.

(Continued on page 212)

FOR SALE

2—Scanlon-Morris, Ohio Chemical Co. Cat. No. 3292, Serial No. 8 "Opray" Multi-Beam, Explosion Proof, Portable Operating Room Lamps. Made for use in rooms where ceiling lamps cannot be installed because of height or other conditions. Due to revision of original plans, these lamps were never put into use. Will sell at 50% of original cost. FOB Cleveland. Reply FS 12, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

GOVERNMENT SURPLUS

X-Ray, physiotherapy, hospital and laboratory equipment, new, used and surplus. Tell us what you need. Your inquiries promptly acknowledged. MEDICAL SALVAGE CO., INC., 217 E. 23rd Street, New York 10, N.Y.

for furniture with a future . . .

Theme by **Simmons Company,** Contract Division.

Left chair, Quadrille pattern in Breathable U. S. Naugahyde. *Right chair,* Bark-textured Elastic U. S. Naugahyde.

Elastic or Breathable U.S. Naugahyde*

the finest in vinyl upholstery

Please your many guests and visitors—save on housekeeping upkeep with this carefree upholstery that offers enduring beauty. In your choice of Elastic U. S. Naugahyde or the new Breathable U. S. Naugahyde.

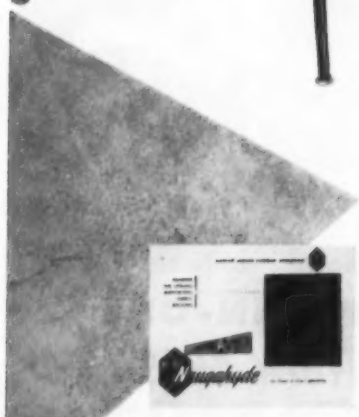
Famous Elastic U. S. Naugahyde (swatched left)

- strong, stretchable fabric backing
- resists splits and tears
- abrasion and scuff resistant
- wipes clean with soap and water
- permanent, bright colors and finishes

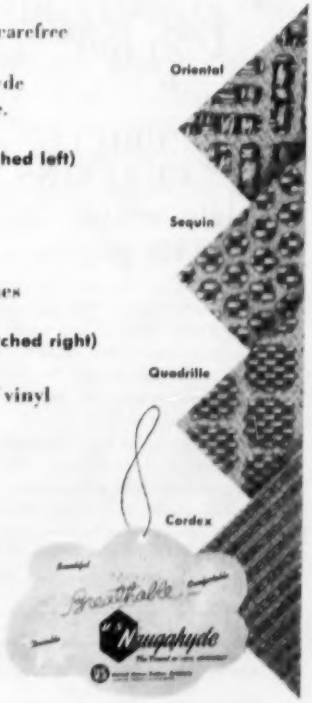
New Breathable U. S. Naugahyde (swatched right)

- breathes like a woven fabric
- has the tough, durable character of vinyl
- cool, comfortable
- fade resistant, washable
- permanent, bright colors
- high tear strength

Specify U. S. Naugahyde, the finest in vinyl upholstery, on all new furniture, or see your local upholsterer.



Burnished Antique, one of seven patterns in Elastic U. S. Naugahyde; in a wide range of beautiful colors.



*Patent Applied for

US RUBBER

UNITED STATES RUBBER COMPANY

Coated Fabrics Department, Mishawaka, Indiana

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SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Ill.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

SCHOOLS—SPECIAL INSTRUCTION

Graduate Hospital of the University of Pennsylvania offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Tuition fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

St. Charles selected again...

in major hospital casework installation

New St. Mary's Hospital addition, nearing completion in Grand Rapids, Michigan, offers still another example of St. Charles success in the field of hospital casework fabrication and installation. Once again, the advantages to be had from St. Charles long years of experience, at work in the nation's newest, most modern casework construction plant, have gained expression in a major hospital.

The reasons for St. Charles continuing preferment are readily apparent. St. Charles methods of custom construction and color styling offer free scope to the imaginative designer. Their broad range of special units, plus the know-how gained from thousands of installations, offers a welcome assist in hospital casework planning. And St. Charles complete design and layout service, freely available in whatever degree it may be desired, puts dependable personnel to work on your job, at once.

Your request for more information will be handled promptly.

Operating Room

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Utility Room

A newly published, 40-page catalog, "St. Charles Hospital Casework," will be mailed to you when requested on your letterhead.

St. Charles

casework • sinks and counters • special purpose units

ST. CHARLES MANUFACTURING COMPANY, DEPT. MH, ST. CHARLES, ILLINOIS

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 240. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it

Cutlery Handle Combats Fatigue

Designed to relieve hand strain for the meat cutter, chef or others in the kitchen, the new Wedgelock Handle was designed by Thomas Lamb, industrial designer. Based on scientific studies of over 700 pairs of human hands, the new handle is designed to be tension-free. It is skillfully contoured to distribute the full strength of the hand in direct relation to the job to be done, easing fatigue, increasing accuracy and control and providing greater safety.

The new Lamb Wedgelock Handle is available on the new Wear-Ever line of professional cutlery. Special blade steels were developed and scientifically tested by Wear-Ever for finest edge-holding qualities and long trouble-free service in the new knives. **The Aluminum Cooking Utensil Co., New Kensington, Pa.**

For more details circle #504 on mailing card.

Four Large Models Added to Spencer Boiler Line

Improved design, new sizes and new features are offered in the line of Spencer "C" Boilers for institutional use. They are now available with standard 15 inch base and with extra base heights. Greater range of application is offered in the four new larger models with three inch fire tubes.

The Spencer "C" Boilers are water-cooled, have precision ground flue and fire-door frames, are equipped with heavy cast iron insulated doors and have extra-heavy steel plate smoke boxes and staggered boiler tubes for rapid heat transfer. Any fuel can be fired in the boilers which are easily and quickly converted from hand to automatic firing. The line is fully approved under the Steel Boiler Institute Engineering Code, according to the manufacturer. **Spencer Heaters, Lycoming Div., AVCO Mfg. Corp., Williamsport, Pa.**

For more details circle #505 on mailing card.

Improved Mopping Buckets Have Snag-Free Joint

Geerpres 32 and 44 quart mopping buckets have been improved by a recessed body bead which strengthens the bucket and provides a snag-free, interlocking joint between the body and the heavy steel reenforcing band. The new buckets incorporate all standard Geerpres features. **Geerpres Wringer, Inc., Muskegon, Mich.**

For more details circle #506 on mailing card.

Compact Device Converts Quickly to Whirlpool Bath

Any bathtub or therapy tank can be easily and quickly converted into a whirlpool bath with the new compact Jacuzzi Whirlpool Bath unit. It has no

exposed switches or moving parts, requires no extraneous plumbing or wiring, and is unconditionally approved by Underwriters Laboratories for professional use, according to the manufacturer. Enough heat is produced to maintain a desired water temperature for the duration of normal treatments.

The compact unit creates 45 gallons of rapidly whirling aerated water per minute. It is completely portable and can be clamped to the rim of a Hubbard Tank or placed in any desired location on a bathtub or other tank. Controls have been especially designed to enable even handicapped patients to regulate the direction and force of the flow without strain or effort and the device is relatively inexpensive. **Jacuzzi Bros. Inc., Hydrotherapy Division, 1440 San Pablo Ave., Berkeley, Calif.**

For more details circle #507 on mailing card.

(Continued on page 216)

Rollpruf Surgical Gloves Color Banded for Size

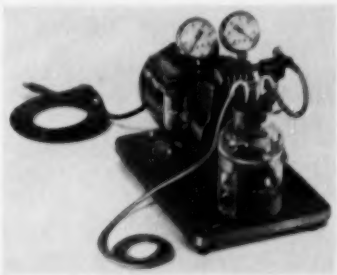
Both the RP-158 and the RP-168 Rollpruf Surgical Gloves are now color banded for easy size identification. Supplementing the familiar "Multi-Sizing" identification now printed across the wrist of each glove, the color banding will speed sorting for size and ensure matching pairs by a glance. **Pioneer Rubber Co., Willard, Ohio.**

For more details circle #508 on mailing card.

Compressor-Aspirator Operates Without Oil

The new Air-Shields diaphragm-type compressor-aspirator for general hospital use operates entirely without oil. Thus the air delivered by the suction-pressure pump is completely free of oil vapor, maintenance care is at a minimum, and it cannot clog or freeze. If aspirated material is inadvertently drawn into the pump, the gauge assembly can be easily removed, the parts washed and dried and the pump reassembled.

The completely adjustable pump can be used for continuous duty operation, is valuable for use with air-operated nebulizers and similar devices, and can be set to deliver any desired pressure up to 30 pounds per square inch. The unit also provides regulated suction at negative pressures up to 20 inches of mercury. The pump is powered by a heavy-duty ball bearing motor which is permanently prelubricated and sealed. It is rubber-mounted on a sturdy, rubber-footed base, has a convenient carrying handle and is supplied complete with large suction and pressure gauges, suc-



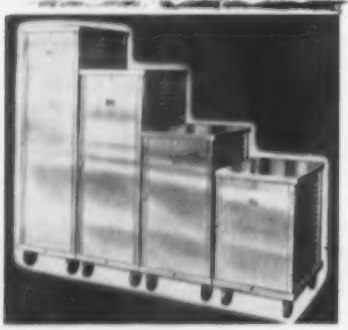
tion bottle with rubber tubing, safety ball trap, dust trap, heavy-duty electrical cord and two Allen wrenches. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #509 on mailing card.

WHAT'S NEW

Utility Cabinets for Food Service

Cres-Cor Hi-Tensile Line Utility Cabinets are designed to permit transfer of food or other items within a building or for truck delivery. They are constructed of extremely hard aircraft-type aluminum for ease of handling and stability under hard use. The corrugated sides support a standard pan and permit spacing to fit



need. An angle-edge, stationary type pan support is available if desired.

The new type, one panel door increases sanitation and is fastened by a newly designed lock. The cabinets are attractive in appearance, easy to keep clean and are available in several sizes. **Crescent Metal Products, Inc., 18901 St. Clair Ave., Cleveland 10, Ohio.**

For more details circle #510 on mailing card.

Safety Alarm for Iron Lungs

A full time watchman for polio patients in iron lungs is available in the polio lung safety device. The device can be attached to any type of respirator. An alarm sounds to warn of falling air pressure, power shortage or the development of any dangerous mechanical condition in the respirator.

The safety device features an "Automatic Reminder" which will sound an alarm if the nurse forgets to remove the patient from the respirator after a specified time or if the switch to turn the device on has not been flipped when the patient returns to the respirator. The device can be rigged to sound an alarm elsewhere in the hospital if desired in addition to that in the patient's room. **Electro-Alarm Safety Devices, 745 Pleasant, Fresno 5, Calif.**

For more details circle #511 on mailing card.

Protective Plates in Attractive Colors

Formica plates have been added to the line of Cipco Contemporary Architectural Hardware. Offered in eleven attractive colors and black, the rugged plates assure attractive appearance over years of wear. Formica is used for kick plates, mop plates, stretcher plates, armor plates and push-pull plates. Colors have been selected to blend with or complement the decorative scheme of the room or other area and the plates are available in any Formica color or pattern on order.

All plates are ⅛ inch thick, beveled four sides and have warp resistant backing for smooth, level application. Necessary screws for attaching are furnished in any finish to match other metal hardware or trim. These protective plates of Formica are wiped clean with a damp cloth and have high resistance to wear. **Cipco Corporation, 22nd & Cole Sts., St. Louis 6, Mo.**

For more details circle #512 on mailing card.

Minatone Acoustical Tile in Half-Inch Thickness

Minatone acoustical tile is now available in an economical one-half inch thickness. Perforations in the new thickness are in the Full Random design used on regular Minatone. The sound absorbing and fire safe tile is available in 12 by 12 and 12 by 24 inch sizes. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #513 on mailing card.

Page Turner Offers Automatic Operation

Pages can be turned either backward or forward with the slightest touch of a turret switch with the Turn-A-Page. This automatic page turner is designed to turn the pages of magazines and books for amputees, patients in iron lungs, or those who are unable to use their arms and hands. It accommodates a range of publications from small books to large magazines and can be used directly on the lap or over bed table when the reader is sitting, or used indirectly through special mirrors when the reader is lying down, as in an iron lung.

The switch mechanism on the Turn-A-Page is so delicate that, when properly

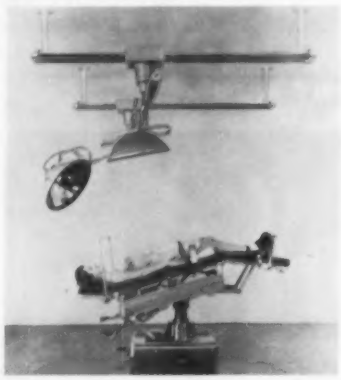
placed, the puff of the reader's cheek or the twitch of his toe is movement enough to operate the machine. A turning arm lifts the page and the wire loop completes the cycle, holding the page flat. The machine measures 24 by 20 inches and is powered by electricity from any standard outlet. **Medical Equipment Laboratories, 3959 Wilshire Blvd., Los Angeles 5, Calif.**

For more details circle #514 on mailing card.

(Continued on page 218)

Light Pattern for Surgery Adjustable with Model DV-22R

The American Dual Video Model DV-22R Surgical Light offers facility for projecting and superimposing light from two different directions, with provision for quickly selecting the size of the light field. The Variac Control offers



an intensity range of 1000 to 15,000 footcandles, offering illumination control for the surgeon's need. The color temperature value is of proper quality to accommodate the requirements of color television when this medium is used for teaching or other purposes. Heat control elements keep the temperatures comfortable for the surgeon.

A simple selecting lever on each of the two light heads provides instant change of light field size. This one light beam can be projected on and into the wound in a manner simulating the conventional large major surgical light pattern illuminating the wound directly from above, while the second light head can be projected at a critical angle into a recess cavity in the same field. Maximum flexibility of the lights is provided for by remote control in all directions from outside the sterile field.

The suspension principle of dual tracks parallel to and covering the length of the operating table places the tracks outside the sterile field. Proper space for a carriage assembly system accommodating either an x-ray head or television camera is provided between the two tracks. The value of x-ray or television in surgical procedures is increased by the positioning of these accessories over the entire table area.

The Dual Video Major Surgical Light, Model DV-22 represents a modern approach to the surgeon's lighting problems in both general surgery and the specialties and provides for x-ray or color television at time of installation or when desired thereafter. There is an on-off switch on each light head and a sterilizable handle for attaching to the light for fine adjustment complementing conventional positioning by remote control. **American Sterilizer Co., Erie 6, Pa.**

For more details circle #515 on mailing card.

Du Pont announces a breath-taking *NEW* creation in vinyl upholstery

NOW! Fabrilite® upholstery breathes for greater comfort...is completely vinyl-coated for soil and wear resistance

Du Pont has developed a revolutionary new kind of "Fabrilite" vinyl plastic upholstery! This "Fabrilite"—in a stunning new pattern called Castleton—contains thousands of invisible pores that permit it to actually breathe for greater sitting comfort. *Completely* vinyl-coated, Castleton offers the *full* advantages of a cleanable plastic.

Because the pores do not break up its continuous vinyl surface, Castleton is exceptionally tough and washable. It offers genuine long wear, and its dry, high-slip finish means less dirt collection—spilled things wipe clean in seconds.

Chemically engineered to stay pliable, this striking new Castleton pattern takes full advantage of its sturdy knitted backing . . . puts an end to stiffening and cracking problems . . . keeps its showroom beauty for years.

All the s-o-f-t comfort of foam-rubber construction now can be realized with vinyl plastic upholstery—if you specify the new "Fabrilite" Castleton pattern that *breathes!* And Castleton also means that now cushions can be made reversible without the use of vents!

Blow smoke right through it! Here's visual proof to show this new Du Pont "Fabrilite" upholstery really breathes. This explains why Castleton has the comfort of a woven fabric . . . plus the full soil and wear resistance of a complete vinyl coating.

Every thread protected from soiling and wear! Here you actually can see how the vinyl coating of Castleton completely covers the knitted fabric support. This locked-for-life surface means outstanding durability plus a stay-clean, easy-to-clean finish.

NEW! An entirely different concept in design* by *Russel Wright*

World-famous designer Russel Wright created Castleton as a "living" abstract pattern . . . the design changes as the light changes! Here is a complete departure in vinyl styling . . . a pattern unlike any leather or woven fabric to have an appeal of its own!

*DESIGN PATENT APPLIED FOR

DU PONT
REG. U. S. PAT. OFF.

Fabrilite®
elastic-supported vinyl upholstery

BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

WHAT'S NEW

Wardrobe Combinations for Patient Rooms and Residences

Designed for built-in or free-standing installation in patients' rooms and nurses' homes and other residences, the new Maysteel Wardrobe Combinations are offered in standardized models. They are available for single, double or multiple purpose room or ward areas.

Rugged construction, modern, decorative fixtures and attractive finishes are features of the roomy wardrobe combinations. Flush double-pan insulated doors and flush drawers are all cushioned with rubber bumpers for quiet closing. The wardrobe portions have space for several large garments, hats, overshoes and an over night bag or brief case. They are available with a full door, or with a door and bottom drawer combination. The wardrobe may be combined with a three or four drawer modified Maysteel vanity or dresser combination with Formica top, or with a lavatory unit including built-in sink with stainless steel top. Arrangements of the units can be carried out according to space, specific needs or decorative preferences. The varieties available permit flexible arrangements to meet all needs. The wardrobe assemblies follow the construction practices of the Hospital Casework Industry, are of top quality and are easy to install. **Maysteel Products, Inc., 740 N. Plankinton Ave., Milwaukee 3, Wis.**

For more details circle #516 on mailing card.

Tumbler Dryer Yields Top Performance

Particularly suitable for hospitals and other institutions where consistently dependable performance is imperative, the tumbler dryer is engineered to yield top performance in tumbler operation. Available is gas, steam or electric heated models, the tumbler dryer is equipped with all safety controls. It is available in three sizes. **Chicago Dryer Co., 2210 N. Pulaski Rd., Chicago 39.**

For more details circle #517 on mailing card.

Examination Cape Is Comfortable and Disposable

A soft, fabric-like material is used for the new Central States Disposable Examination Cape. It is designed so that one size fits all adults. The cape slips easily over the head and is held in place with a tie string around the waist. It is opaque, pleasant to the touch and comfortable to wear. The low cost makes the capes practical for use in replacing gowns or sheets and eliminates the laundry problem. **Pro-Tex-Mor Hospital Division, Central States Paper and Bag Co., 5321 Natural Bridge Ave., St. Louis 15, Mo.**

For more details circle #518 on mailing card.

Floor Machine Handle Increases Use

The new three-way handle on the Advance Gyro 12 Floor Polishing and Scrubbing Machine gives the unit greater versatility. It handles as easily as a home type vacuum cleaner when the handle is in the "free" or "floating" position. The safety switch and bal-

anced design make it possible for unskilled help to use the machine effectively.

The Gyro 12 operates as a conventional self-propelling floor machine with the handle locked, and moves back and forth across the floor as the handle is raised and lowered. With the handle locked in the vertical position the machine tilts back for easy transport to storage or to place of use. It can be stored in minimum space. **Advance Floor Machine Co., 2613 Fourth St. S.E., Minneapolis 14, Minn.**

For more details circle #519 on mailing card.

Hematocrit Model Conducts 36 Tests Simultaneously

Utilizing the new improved Guest-Siler technic with heparinized capillary tube, the Series 54 "Electrifuge"-Hematocrit model is designed to conduct 36 tests simultaneously. The new Centrifuge features a high speed ball-bearing motor, a built-in timer which can be set for any period up to 15 minutes and motor bearings which are grease-sealed for life. **Chicago Surgical & Electrical Co., 217 N. Desplaines St., Chicago 6.**

For more details circle #520 on mailing card.

(Continued on page 222)

Food Waste Disposer Effective as Pre-Wash Unit

Model "JH" Waste-X-It is a versatile new food waste disposer capable of heavy duty performance. It can be installed in preparation or scrap tables with economical cone adapters. An overhead spray and salvage basin make it possible to use the unit as a combination scrapping and pre-wash facility. **The Salvajor Co., 118 Southwest Blvd., Kansas City 8, Mo.**

For more details circle #521 on mailing card.

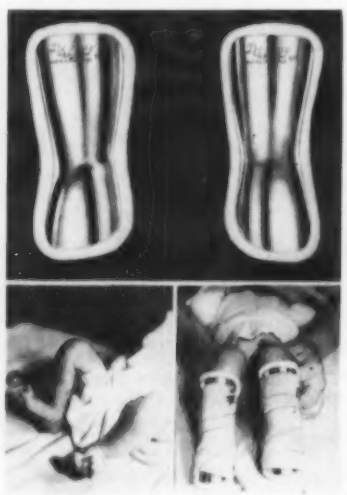
Operating Gown Has Sterile Back

The Rhoads Sterile-Back Operating Gown has a lap-under back with gripper snap fasteners. It is simple, comfortable, inexpensive and easy to put on and remove. The "locked-in-flap" construction ensures complete coverage in any position and fits neatly and comfortably. The gown has improved tunnel belt with buttonholes that do not tear, free shoulder action, extra large sleeves, double seams throughout of 3 cord service thread, and double six inch stockinette cuffs. It is made of Cordene sanforized fabric in white or colors. **Rhoads & Company, 401 N. Broad St., Philadelphia 8, Pa.**

For more details circle #522 on mailing card.

Tip-Toe Splint for Infant Corrections

Developed at the Lincoln Orthopedic Center, Lincoln, Nebraska, by Dr. C. F. Ferciot, the new DePuy Tip-Toe Splint is designed to correct the severe flexion contracture of the ankles in the newborn to prevent the development of calcaneal valgus deformity and pronated feet. The extension splint can be bandaged in the position of correction and is easily re-

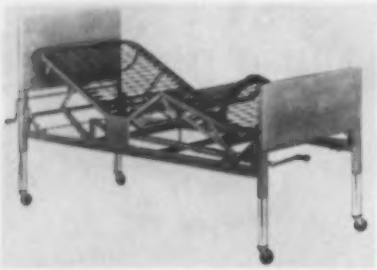


moved for bathing and exercise. The new splint is sturdy, well constructed and inexpensive and correction is usually obtained in a few weeks. **DePuy Manufacturing Co., Inc., Warsaw, Ind.**

For more details circle #523 on mailing card.

WHAT'S NEW

Multi-Height Bed in Supersize



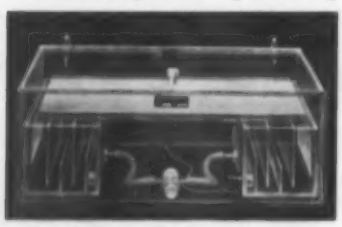
The new No. 871 Inland Multi-Height hospital bed is available in two lengths, the standard 82 inches for 76 inch mattress and the new 86 inch overall for 80 inch mattress. The Multi-Height feature is offered with the No. 8 Inland All-Position Heavy Duty Gatch Spring. Height of spring is adjustable by a crank which easily raises or lowers bed inserts.

The bed can be raised to 27 inches for nursing service, lowered to 18 inches for patient comfort and convenience, or stopped at any intervening height desired. The crank can be inserted at either side of the bed ends and when not in use can be stored in a special receptacle beneath the head panel. Individual adjustments of the head and foot ends permit a full range of Trendelenburg, Hyperextension, Reverse Trendelenburg, Fowler and intermediate positions with simple crank adjustment. **Inland Bed Company, 3921 S. Michigan Ave., Chicago 15.**

For more details circle #524 on mailing card.

Paper Electrophoresis Apparatus in Two Models

A research model of paper electrophoresis apparatus is offered in the Model 1400, illustrated. Paper strips can be used in open suspension or between glass plates as the enclosing plastic cabinet serves as a vapor saturation chamber. Each plastic buffer vessel has five chambers with vertical baffles. Easy detachment of lead-in wires from electrode terminals is possible with the improved electrical connections. When the hinged cabinet lid is lifted the high-voltage current is automatically cut off. The unit is compact and light in weight,



permitting it to be placed in a refrigerator when temperature control is desired.

Model 1405 Paper Electrophoresis Apparatus is designed for routine work where refinements of research instruments are not needed. The paper strip is suspended in a horizontal position at the top for convenient use without interference of pressure plates. The design is simple and the unit incorporates the functional advantage of the enclosed vapor saturation chamber. When assembled the unit constitutes a completely enclosed vapor chamber. **Research Specialties Co., 1148 Walnut St., Berkeley 7, Calif.**

For more details circle #525 on mailing card.

Blood Administration Set Incorporates Pressure Pump

The new Baxter Plexitron R48 Combination Set provides for switching from the normal rate of giving blood to rapid administration under pressure. The expendable administration unit can be switched in two or three seconds for speedy administration. During normal use the drip chamber is filled with blood to level just above the filter and the rate of administration is regulated with the

control clamp. When the need for pressure arises, the control clamp is opened and the flexible drip chamber is pumped with a squeeze-release action. When the drip chamber is squeezed, blood is forced downward into the patient's veins. When released, the chamber refills with blood from the bottle and is ready for the next squeeze. The operator can return to normal administration at any time. The R48 offers maximum safety for the patient as the arrangement prevents the pumping of air. **Baxter Laboratories, Inc., Morton Grove, Ill.**

For more details circle #526 on mailing card.

Enriched Flour for Institutional Use

An all-purpose enriched flour is now being introduced for the institutional market. It is packaged in 25 pound paper and 100 pound cotton bags and is suited for food service operations. **Monarch Finer Foods Division, Consolidated Foods Corp., 135 S. La Salle St., Chicago 3.**

For more details circle #527 on mailing card.

(Continued on page 226)

Patient Positioning Facilitated With Collo Blocks

Carefully compounded plastic that is completely radiolucent and free of all artifacts is used for the Collo All-Foam positioning blocks. The material is resilient for comfortable positioning of all patients preparatory to and during x-ray examinations. It is non-absorbent, non-inflammable and will not slip or skid once it is placed. Collo All-Foam is dimensionally stable and is warm to the touch. It can be sterilized wet or dry. Blocks of Collo All-Foam are available in a wide variety of sizes and shapes for all positioning needs, including wedges, cubes, bevels, cylinders, discs, bands and pads. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y.**

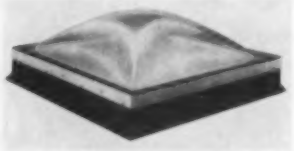
For more details circle #528 on mailing card.

Plastic Skylight Is Vacuum Insulated

Moisture condensation is eliminated with the new Dubl-Dome Vacuum insulated skylight, thus overcoming the possibility of condensate drip. The high insulation value provided with the new skylight helps to reduce heating costs.

A permanently sealed vacuum between the upper and lower domes also restricts the transmission of exterior noises and keeps dust and dirt out of the area. The center stress member is a single flat sheet of plexiglas. It permanently stablizes the unit, regardless of atmospheric temperature and pressure changes. The upper unit is transparent and the lower translucent for light diffusion.

The Dubl-Dome skylight is shipped ready to place over the curb for rapid installation. The unit can be installed on roof slopes up to 30 degrees. It is available in ten convenient sizes in the following combinations: upper dome and inner member clear Plexiglas and lower



dome white translucent Plexiglas, or upper and lower domes, clear Plexiglas and inner member white translucent Plexiglas. **Bettcher Plastics Co., 1616 N. W. Glisan St., Portland 9, Ore.**

For more details circle #529 on mailing card.

Whatever your needs may be . . . see

Lloyd

the fine quality, economical furniture designed for smart appearance; made to take the wear and tear of commercial use.

CAPRI Upholstered Capri shown above has comfortable seat cushions with foam rubber and spring construction. This furniture as well as All-fibre Capri (not shown) has the famous Lloyd extra-strong patented (*U. S. Patent No. 2,234,677) woven fibre with baked on finishes in smooth decorator-selected shades. Tubular metal construction makes Capri lightweight and easy to move, yet exceptionally strong and rigid.

OUTDOOR furniture finishes keep their colorful good looks year after year because they're baked on; steel parts treated for rust-resistance. Lightweight, easy to move Outdoor Furniture has the famous Lloyd patented woven fibre seats and backs that last practically forever. Black or white frames; woven fibre in black, white, pink, green, yellow.

COMMERCIAL CHROME is quality throughout—from steel tubing made in our own plant to finishes applied with all the skill of our long experience. Upholstery and table-top materials are selected with equal care—to make sure that Lloyd furniture for lounges, recreation rooms, restaurants and offices gives a full measure of long, economical service.

MAIL COUPON TODAY

for the latest catalog and name of the nearest distributor of Lloyd Furniture.

LLOYD MANUFACTURING CO. (a Division of Heywood-Wakefield Co.) Menominee, Michigan, Dept. MH-4 Please send me

☐ Lloyd Capri Catalog ☐ Lloyd Outdoor Catalog ☐ Lloyd Chrome Catalog

NAME .....

NAME OF INSTITUTION OR BUSINESS .....

.....

CITY ..... ZONE ..... STATE .....

WHAT'S NEW

Baker Boy Ovens Now Have Dual Tray

A dual tray which is easily installed or removed above the regular tray is

provided in the new model Baker Boy oven. This permits the baking of limited amounts of bread with pastry and other special items.

The exterior design has been improved by a complete porcelain panel above the door with white Dulux panels. Stainless steel is used for trim at top and bottom as well as for the door frame to facilitate maintenance and cleaning. The uniform flow of power to the reel simplifies assembly, installation and service. The new model has the standard Despatch "Moist-Master Steamdome" providing moisture-wiped baking without extra cost. This feature with the exhaust system also permits the baking of bread, rolls, eclairs and other foods at the same time without flavor exchange. The oven can also be used for baking and roasting meats. It is available in six sizes. **Despatch Oven Co., 619 S. E. 8th, Minneapolis 14, Minn.**

For more details circle #530 on mailing card.

Metal Protective System Prevents Rust

The preservation and decoration of iron, steel and non-ferrous metals are achieved with the new Bar-Ox Metal Protective System. Bar-Ox is easy to apply by brush, spray or roller. It dries quickly to a hard, tough, water-impermeable film with a full-gloss effect which holds. The coating is resistant to sun and weather, to moisture and to fumes in the atmosphere. It is available in colors and in black and white. **Truscon Laboratories, Caniff and G.T.R.R., Detroit 11, Mich.**

For more details circle #531 on mailing card.

Light Controls for Fluorescent Lamps

Luxtrol light controls used in conjunction with ballasts designed for the application offer a new low cost method of controlling the light intensity of rapid start fluorescent lamps. The problems of warm-up time and tube replacement are eliminated with this system. **The Superior Electric Co., Bristol, Conn.**

For more details circle #532 on mailing card.

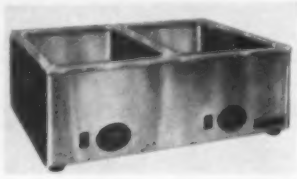
Asphalt Roof Shingles Are Wind Resistant

A wind and water resistant asphalt roof shingle which seals itself to the one below by means of a petroleum resin adhesive has been developed by Johns-Manville. The adhesive is applied to the shingle, known as the Seal-O-Matic, at the factory. After exposure to the sun's heat it softens and merges with the shingle below. Thus, each shingle is continually welding itself to the one below. Seal-O-Matic shingles are available in a range of blends and colors in strips 12 by 36 inches with three square cut butts. **Johns-Manville, 22 E. 40th St., New York 16.**

For more details circle #533 on mailing card.

Food Storage Units for Counter Use

The Scotty Electro-Matics are counter units designed for dry or moist hot food storage. The one-piece stainless steel clad wells used on the Seco-Matic Hot Food Tables are used in the new Electro-Matics which have standard 12 by 20 inch openings to accommodate any of the hundreds of Seco-Ware food storage pan combinations. Each well is individually controlled to provide either dry or moist



uniform heat concentration around each food.

Each of the new completely redesigned units has an overall height of 10⅛ inches and is equipped with a Westinghouse Corox 800 watt heating element with thermostatic control. Two standard sizes are available, one opening and two opening. **Seco Company, Inc., 5206 S. 38th St., St. Louis 16, Mo.**

For more details circle #534 on mailing card.

Knitted Diapers for Nursery Infants

A special size and style of Pant-ease Diapers has been developed especially for hospital use. The knitted diaper in the new size is smaller than standard, to fit newborn infants in the nursery. Pant-ease Diapers are easy to change, fold and sort, are laundered with no twisting or tangling, and have long life. They are quickly identified as diapers and are less easily lost or diverted for other uses. Only one fold is required and the diaper is quickly put on or taken off the infant. The knitted fabric makes the diapers comfortable and prevents the possibility of binding or chafing. **Pant-Ease Infant Wear Co., Arcade, N.Y.**

For more details circle #535 on mailing card.

(Continued on page 228)

Generating Plant for Emergency Institutional Use

A new 75,000 watt capacity emergency electric generating plant has been developed to meet the increased electrical requirements of modern hospitals and other institutions. The new Onan-built generator in the high-capacity standby electric plant has been specifically designed to provide excellent electric motor starting. This makes it especially suitable for use in hospitals where much equipment is operated by electric motors.

If desired this heavy-duty generating plant will provide dependable, economical power for daily use. Known as Model 75HR, the new unit is gasoline-engine driven, powered by a Continental six cylinder engine. The generators are designed to permit parallel operation if desired and two or three units can economically serve a large load. **D. W. Onan & Sons Inc., 6251 University Ave., Minneapolis 14, Minn.**

For more details circle #536 on mailing card.

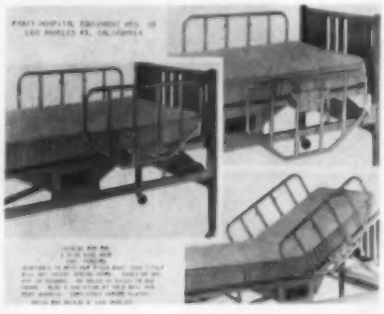
Pin Free Diaper Is Readily Adjustable

Made exclusively for newborn babies, the Pin Free Diaper has four stainless steel snaps, making it adjustable and eliminating the use of pins. It is made of a double layer of Red Star Birdseye cloth with eight layers of gauze inside for absorbency. **Sherman Mills, 77 Bedford St., Boston 11, Mass.**

For more details circle #537 on mailing card.

Bed Gate Operates With Rotary Motion

The new Pratt Half Side Bed Gate serves to protect the patient in all except severe cases. It moves up and down by a simple, rotary motion and is easily turned down out of the way during nursing care or when no longer required. It is adaptable to most hospital beds and is so designed that it cannot injure the bed spring frame. The bed gate is easily snapped on or off in a matter of seconds and is installed without the necessity of drilling holes in the bed



frame. It is chrome plated for attractive appearance and easy maintenance and sanitation. **Pratt Hospital Equipment Co., 3007 Southwest Drive, Los Angeles 43, Calif.**

For more details circle #538 on mailing card.

WHAT'S NEW

Radiographic Intensifying Screen Produces Fast Response

The new Du Pont "Patterson" Lightning Special radiographic intensifying screen is designed to produce the fastest available response in the medical kilovoltage range. Uses of the new screen include portable and bedside radiography, spot-film radiography, operating room radiography, angiography and grid cassettes where the speed of operation reduces time, produces effective results and reduces radiation exposure to personnel. It is a special purpose screen which does not supplant other Du Pont intensifying screens. The Lightning Special has an individual identifying serial number stenciled on the edge of each screen. **E. I. du Pont de Nemours & Co., Wilmington 98, Del.**

For more details circle #539 on mailing card.

Drop-In Waste Receptacle Has Unobstructed Opening

All around accessibility and fast deposit of refuse are features of the new

Bennett Drop-in Waste Receptacle. Moving parts, breakage and adjustments are eliminated as waste is dropped in the unobstructed top opening. The receptacle is complete with full size, watertight galvanized liner which is equipped with a swing handle for fast emptying. **The Bennett Mfg. Co., Alden, N.Y.**

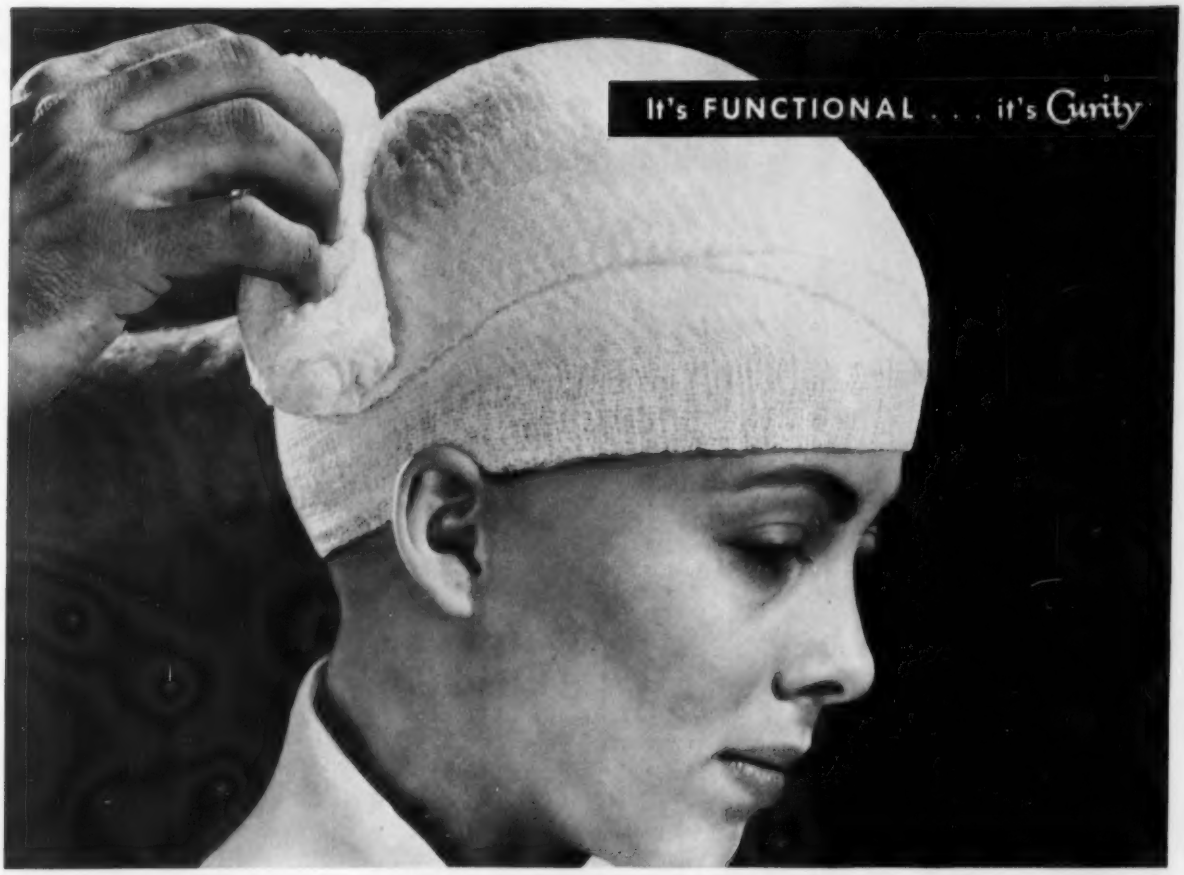
For more details circle #540 on mailing card.

Faucet Washer Screws Cut Maintenance Time

Monel "Self-Locking" faucet washer screws cut repair time and eliminate washer failure caused by faulty screw installation. Ten sizes of these "Self-Locking" screws, which can be carried in the special "Handy Andy" metal box, do the job of 37 sizes. The screws do not work loose or ruin the washer, yet they are easily removed and reuseable. **J. A. Sexauer Mfg. Co., 2503-05 Third Ave., New York 51.**

For more details circle #541 on mailing card.

(Continued on page 230)



NOW! DRESS PROBLEM AREAS in 1/2 the time

Kerlix Roll "molds itself" to any part of the body

Here's a soft, conformable dressing you can use on any body area (even stumps and head). *Kerlix* goes on smoothly and quickly and easily. And won't skid out of place.

Kerlix Roll is woven with threads permanently crinkled by a special process. These soft crinkled threads make *Kerlix* exceptionally conformable. *Kerlix* is unique—the only dressing ever to combine all these qualities: Resilience. Fluffiness. Mild elasticity. And *Kerlix* is fully absorbent, too.

With *all* these characteristics, *Kerlix* Rolls have dozens of uses. (The box on right just begins to list them.) Undoubtedly a use in your hospital. Contact your *Curity* man today. Or mail us your name and address and we'll send you a free sample supply so you can feel and use *Kerlix* yourself.

ECONOMICAL! Costs far less than ordinary gauze rolls or elastic bandages

Here's where hospitals are now using this functional *Curity* Kerlix dressing for better patient care:

All hard-to-dress areas • Burns • Mastectomies • Amputations • Plastic surgery • Skin grafting • Uterine packing • Umbilical binders • Colostomy stoma rings.

Kerlix Rolls (4½ yd.) in non-sterile cases for hospitals and doctors. Also Kerlix Gauze (5½ yd.) in sterile boxes . . . all 4½" wide.

Curity
REG. U.S. PAT. OFF.

KERLIX®
ROLLS

BAUER & BLACK
Division of The Kendall Company
309 West Jackson Blvd., Chicago 6, Illinois

WHAT'S NEW

Crib Fracture Set for All Pediatric Traction

All types of child traction can be put into effect with the new Chick-Leinbach Crib Fracture Set. It is simple to use and convenient to store, fits any metal

or wood crib without damage to the finish, and is quickly assembled as needed. It provides all angles of traction, has interchangeable parts and swivel jointed pulleys, and is light in weight. **Gilbert Hyde Chick Company, 821-75th Ave., Oakland 21, Calif.**

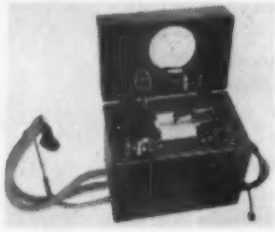
For more details circle #542 on mailing card.

Hot Chocolate Drink Made Instantly

A continental style hot creamed cocoa drink is available for instant preparation with hot water. Known as Brown Swiss, it is processed from pure cream, milk solids and the finest quality cocoa. Instantly soluble, Brown Swiss is prepared by the addition of hot water only and provides a nourishing hot drink which has an excellent flavor and the quality of hot chocolate made with whole milk or cream. It is supplied in cases containing three hundred 1¼ ounce envelopes, each making one cup; twenty-four 15 ounce tins, each tin making 12 cups, or six No. 10 tins, each tin making 2½ gallons. All sizes are gas packed in air tight containers to ensure freshness. **Webster Van Winkle Corp., Summit, N.J.**

For more details circle #543 on mailing card.

Meta-Basal BMR Machine Is Modern and Portable



A completely portable BMR machine is offered in the Meta-Basal. It is precision-engineered for complete accuracy and simple operation. Oxycaps containing one liter of factory certified O_2 at STSP, eliminate temperature or pressure calculations and slip easily into the machine. A clog-proof pen that does not stain hands, blur or smudge records, is used with the Thermoscribe for automatic recording. The low impedance, equi-tension bellows provide normal, comfortable breathing in any position. Sufficient CO_2 absorbent for 100 tests is supplied in a bag which is readily replaced as needed. The compact unit fits into a carrying case for easy portability. **Electro-Physical Laboratories, Inc., 30 Huntington Ave., Boston 15, Mass.**

For more details circle #544 on mailing card.

Hi-Lo Lectern Adjusts For Speaker's Height

Speakers of any height will find the Hi-Lo Lectern ready for their convenient use. The all-purpose lectern can be adjusted in height from 37 to 44 inches at rear to accommodate any speaker comfortably. Two inconspicuous buttons operate the movement of the lectern top up or down. Electric operation is instant, positive and simple. For table top use, the lectern top is removable by simply lifting it from the stand. The top plugs automatically into the base when replaced.

The Hi-Lo Lectern is available in a

choice of finishes to harmonize with any background. It is equipped with an adjustable shaded lamp, has ball bearing casters in front for easy mobility, and is powered by plugging into any light outlet. The entire power mechanism is housed in the lower cabinet which provides shelf space for storage. **Detroit Lectern Co., 13336 Kercheval Ave., Detroit 15, Mich.**

For more details circle #545 on mailing card.

Photocopy Paper for Use in Light Areas

Photocopy equipment can be operated in areas using bright lights with the new Apeco Fog-Resisting Photocopy Paper. The paper has high light-resistant qualities and results in sharper copy, higher contrast and less exhaustion of developer. **American Photocopy Equipment Co., 1920 W. Peterson Ave., Chicago 26.**

For more details circle #546 on mailing card.

(Continued on page 232)

WHAT'S NEW

Anti-Bacterial Action in Germ-Aseptic Liquid

Scientific protection against the growth of micro-organisms is offered in the new clear, odorless liquid known as Germ-Aseptic. It imparts anti-bacterial properties to surfaces and leaves residual protection until the next cleansing process. It is effective in sanitizing floors, walls, rugs, tile, linoleum and sanitary facilities and provides anti-bacterial and anti-fungal treatment. It has no unpleasant odor and prevents the cause of malodors by removing bacteria.

Germ-Aseptic has passed the United States Government specifications for mildew proofing tests, according to the manufacturer. Surfaces treated with Germ-Aseptic are said to resist mildew, rot and musty odors. There is no soap scum, rinsing after use is not necessary, and no additional cleansing agents are required. **Germicidal Corp. of America, 41 E. 42nd St., New York 17.**

For more details circle #547 on mailing card.

Portable Welder for Building Maintenance

Maintenance and repair work in and around a hospital or other institution can be handled with the Royal Arc 200A portable welder. The small, compact unit, weighing only 59 pounds, can be carried from room to room or building to building as needed. It will perform all types of welding work when plugged into any 110 or 220 volt outlet. The unit can be used to cut, braze, solder, preheat and hard-surface parts and can be operated by any maintenance personnel without previous welding experience. The Royal Arc 200A welds with electrodes from 5/64 inch up to and including 5/32 inch. **Royal Arc Industries, Inc., Chillicothe, Ill.**

For more details circle #548 on mailing card.

Corbin Locks and Latches Are Redesigned

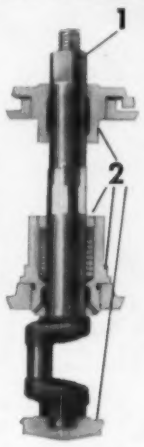
The redesigned and reengineered "900" Series of Corbin Unit Locks and Latches incorporate the Corbin exclusive locking principle which makes for easy and fast installation. The Unit Locks have frames made of strong extruded brass metal and all internal parts are made of non-ferrous metal or zinc-plated, dichromated steel. **P.&F. Corbin Div., The American Hardware Corp., New Britain, Conn.**

For more details circle #549 on mailing card.

(Continued on page 234)

No Place for "Boomps-a-Daisy"

THOUGHTFUL SELECTION of door closers for your hospital will avoid awkward situations such as unpredictable closing speeds, frequent repairs, time-consuming adjustments, and even accidents.



In your search for the precise door closer that offers the most advantages, consider the *Russwin hydraulic surface door closer.* Among its outstanding features are (1) spindle of one-piece drop-forged steel, carefully machined and accurately ground to a smoothness that eliminates friction, assures long life (2) four-bearing support of spindle . . . also special design of valve allowing all available spring power to overcome latch resistance; low freezing point liquid; simple design for servicing.

Hundreds of hospitals like the Kent County Memorial Hospital of Warwick, R. I. are equipped with Russwin Surface Door Closers and other Russwin hardware specifically designed for hospital service . . . locks and latches, push and pull plates, fire exit bolts, door holders and miscellaneous trim hardware. For more details consult the Russwin 12-page section in Sweet's Architectural File or your authorized Russwin specialist. Russell & Erwin Division, The American Hardware Corporation, New Britain, Conn.

The attractive, modernly-equipped Kent County Memorial Hospital of Warwick, Rhode Island.

SINCE 1839
RUSSWIN®
DISTINCTIVE HARDWARE

WHAT'S NEW

Rhinoplastic Saw Is Electrically Operated

Speed of cutting through the maxillary processes is one of the advantages offered in the electrically operated, oscillating Seltzer Rhinoplastic Saw. Introduced by Dr. Albert P. Seltzer, the saw cuts the

bone smoothly and efficiently without cutting soft tissue. The handpiece has a fine toothed, fan shaped blade which oscillates at high speed for fast cutting through the bone. Both handpiece and flexible shaft may be autoclaved. The motor unit hangs on an I.V. stand. Included in the complete unit are a carrying case, motor, foot switch, flexible shaft, Rhinoplastic Saw handpiece, extra blade, extension shaft and combination saw holder and lubricant cup. **Orthopedic Frame Co., Kalamazoo, Mich.**

For more details circle #550 on mailing card.

Safti-Dropper Protects Against Accidents

Safe administration of vitamins to infants is provided with the new Mead Safti-Dropper. The possibility of chipping or breaking of the applicator is removed with the plastic dropper which permits administration directly into the infant's mouth without danger of accident. The dropper is individually sealed in a sanitary cellophane wrapper and is supplied with Poly-Vi-Sol and Tri-Vi-Sol for administration to infants. **Mead Johnson & Company, Evansville, Ind.**

For more details circle #551 on mailing card.

Portable Tape Recorder Has Editing Key

The new Pentron Multi-Speed Portable Tape Recorder Model TR-4 has an editing key for deletion of recorded material or for spot recording while playing back tape. It has dual speed, dual track operation with push-button for changing from tape speeds of 3¾ or 7½ inches. It is a dual track recorder which is also available with full width, single track heads.

All controls are within the span of the hand and the recorder offers high fidelity reproduction. The new model has all of the Pentron features and a completely redesigned case, constructed so that the lid may be closed for operating and carrying with 5 or 7 inch reels. There is additional storage space for tape and accessories. **Pentron Corporation, 777 S. Tripp Ave., Chicago 24.**

For more details circle #552 on mailing card.

Institutional Vacuum for Light or Heavy Cleaning

The E-200 institutional vacuum cleaner is suitable for all jobs, from the heaviest volume wet or dry pickups to the lightest vacuuming or blowing. The E-200 is extremely portable and is mounted on four large free-turning casters and moves easily in any direction. A full range of attachments is available for the vacuum cleaner. **Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn.**

For more details circle #553 on mailing card.

Shaking Incubator Has Many Uses

The Labline-Dubnott Incu-Shaker is a new shaking incubator holding 36-20 ml beakers. It is suitable for numerous studies where results can be obtained without determination of manometric pressures or volume changes, including incubation of tissue slices and homogenates, aerobic and anaerobic studies of tissue slices and homogenates, protein coagulations and other applications where constant temperature and shaking are necessary. It employs temperatures up to 100 degrees C. and shaking speeds up to 150 strokes per minute. The unit is made of stainless steel with built-in water and rheostat speed control. An interchangeable holder for other sizes of beakers and flasks is available. **Labline, Inc., 217 N. Desplaines St., Chicago 6.**

For more details circle #554 on mailing card.

Copying Machine Handles Books or Papers

Anything that can be held against the glass, including books and other bulky material, can be copied with the new Photorapid Compak. The unit can also be used to make transparencies for use as masters with diazo or blueprints or for burning in positive offset plates.

The compact, portable unit is easy to clean as the developing tray lifts out for simplified cleaning and closes tight when not in use. The non-metallic tank pro-

tects against corrosion and the machine operates with only one dial to turn. It is available in two sizes for desk-top operation. **Copy-Craft, Inc., 105 Chambers St., New York 7.**

For more details circle #555 on mailing card.

(Continued on page 236)

Nurses are enthusiastic about Castle's new 3-minute Emergency Instrument Sterilizer. Engineers say its all-welded Monel construction...

ups sterilizer efficiency still another notch

You get no corrosion inside these modern sterilizers. They're solid Monel®.

You get no chipping. No peeling. Units heat fast, clean easily. Their safety is extremely high. Their life is long. They aren't harmed by saline or other hospital solutions.

Efficiency keynotes Resurrection's bulk units, too. Like the cylindricals, they were also supplied by Castle and have many of the same features. For economy, Castle makes them of Nickel-Clad Steel.

Now, for the outside, too

Engineers know that when inner and outer shells are different metals, they expand and contract at different rates. Monel has proven beyond question its value as an inner shell material. So now, Castle makes the outer shell and end ring (door collar) of Monel, too. Solid Monel. Then they weld all three into one solid unit that stays tight.

You reap the benefits. Corrosion resistance throughout. Long life.

Notice the other features of these Castle units

The photographs here show recent Castle installations at Chicago's new Resurrection Hospital . . . the 3-minute unit, top right . . . a 30-minute unit, top left . . . a Nickel-Clad Steel bulk unit in the small photo. Examine them closely. Notice the self-centering doors, the easy-to-use, clear reading Thermatic Control. Notice, too, the Monel trays.

For information on these units and other new designs, write Wilmot Castle, 1700 E. Henrietta Rd., Rochester 18, N. Y. Or call their local office.

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street New York 5, N. Y.

INCO NICKEL ALLOYS

Monel . . . for low maintenance sterilizers

WHAT'S NEW

Hamper Bag Is Self Closing

A simple method is employed to close the Ropeless Hamper Bag without tying when it is filled with linen. The bag is quickly closed by simply turning a special flap over the top. It is carried by an attached handle and when it reaches the laundry or other department, it is quickly emptied by turning the flap back to its original position.

With the new bag repairs, ropes, grommets and lost time are eliminated and work is speeded. There are no knots to tie or untie and the bag remains securely closed when sent down the laundry chute. The bag is sturdy and durable. **The Self Closing Ropeless Bag Co., 36 Woodland St., Hartford, Conn.**

For more details circle #556 on mailing card.

Wheelchair Seat Can Be Elevated

The Arnold Hydraulic Elevating Seat for wheelchairs permits the patient to transfer himself easily and quickly from one level to another. This facilitates transferring from bed to wheelchair and back, into an automobile or into a chair.

The chair seat is operated by a simple mechanism which lowers and raises the

seat without bulky equipment. The elevating seat can be installed on any type wheelchair. **Arnold Devices, Inc., 310 E. 34th St., New York 16.**

For more details circle #557 on mailing card.

(Continued on page 238)

BACTERIA TAKE A FREE RIDE ON ANYONE IN THE HOSPITAL!

Bacteria are hitchhikers . . . and they travel on the hands of EVERYBODY IN THE HOSPITAL . . . nurses, aides, kitchen workers, maintenance personnel and visitors.

Surgeons keep the bacteria count on their hands low . . . but it's almost equally important for the others. Here's a practical, economical plan, to provide this same surgical asepsis for everyone in the hospital.

Modern science has now provided a time-saving, highly efficient germicide . . . Hexachlorophene . . . which Huntington makes available in Germa-Medica at low cost. Put it in all your soap dispensers throughout the hospital . . . it's positive insurance against the spread of contagion.

Use like ordinary liquid soap. Germa-Medica with Hexachlorophene is convenient and simple to use correctly. It's a *proved bacteriostat that costs only 1/5c per hand wash.* It is low cost because Germa-Medica is highly concentrated and is diluted with four parts of water before use. After dilution, tests prove that daily three-minute scrubs reduce the bacteria count well below safe levels and keep it down.

Get a sample for testing now. See how mild yet effective this new soap is. You'll make a real forward step in sanitary technique in your hospital when you start using Germa-Medica with Hexachlorophene in all your wash rooms. Write us today.

EVERYONE IN THE HOSPITAL NEEDS

GERMA-MEDICA®

LIQUID SURGICAL SOAP WITH HEXACHLOROPHENE

HUNTINGTON LABORATORIES

HUNTINGTON, INDIANA

PHILADELPHIA 35, PA. TORONTO 2, ONTARIO

WHAT'S NEW

Pharmaceuticals

Pamine Bromide

Pamine Bromide is an anti-ulcer drug now offered as a pleasant tasting syrup, in addition to the tablet form previously available. Pamine is also available combined with phenobarbital in dosage suitable for infants with gastrointestinal disturbances. It is administered by dropper. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #558 on mailing card.

Hypaque

Hypaque is an excretory radiopaque which is said to produce an unusually high percentage of satisfactory urograms. The new contrast medium contains 59.87 per cent iodine and is highly water soluble. It is supplied in a 50 per cent sterile aqueous solution, in 30 cc ampules. **Winthrop-Stearns Inc., 1450 Broadway, New York 18.**

For more details circle #559 on mailing card.

Mycostatin

Mycostatin is a safe antifungal antibiotic for use in the prevention and treatment of intestinal moniliasis. It may be used in conjunction with broad spectrum antibiotics to prevent intestinal proliferation of Candida. It is virtually non-toxic, is compatible with commonly used oral antibiotics, and is supplied in 500,000 unit tablets in bottles of 12 and 100. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #560 on mailing card.

Ansolysen

Ansolysen is a new ganglionic blocking agent which is effective in the management of moderately severe, severe and malignant cases of hypertension. It acts by blocking sympathetic nerve ganglia which decreases peripheral resistance and lowers blood pressure. The product is supplied in 40 and 100 mg. bottles of 100. **Wyeth Laboratories, 1401 Walnut St., Philadelphia 2, Pa.**

For more details circle #561 on mailing card.

Alflorone Acetate

Alflorone Acetate is a derivative of hydrocortisone which possesses a greatly increased anti-inflammatory activity making long-term treatment of chronic skin conditions practical and economical. It is available as Topical Ointment of Alflorone Acetate 0.1 per cent and 0.25 per cent, both in an emollient base. Both strengths are available in 5 gm. tubes. **Sharp & Dohme, 640 N. Broad St., Philadelphia 1, Pa.**

For more details circle #562 on mailing card.

(Continued on page 240)

Rau-Tab Tablets

Rau-Tab tablets, for the control of mild to moderate hypertension, labile hypertension in young or psychoneurotic patients and management of angina, is supplied in scored tablets for oral administration. It is the alseroxylon fraction of Rauwolfia Serpentina in tablet form, 2 mg. per tablet. **National Drug Co., 4633 Stenton Ave., Philadelphia 44, Pa.**

For more details circle #563 on mailing card.

Prydon and Prydonnal Spansules

Prydon Spansule capsules provide sustained release of the optimally balanced formulas of belladonna alkaloids in oral dosage form for prolonged, uninterrupted anticholinergic activity in peptic ulcer, hypersecretion and spastic conditions of the G.I. tract. They provide continuous protection all day or all night with one oral dose, smooth therapeutic response, minimum side effects and effective control. The product is also available with 1 gr. of phenobarbital in Prydonnal Spansule capsules to add sedative action where desired. Prydon is available in 0.4 and 0.8 mg. and Prydonnal in 0.4 mg., each in bottles of 30 Spansule capsules. **Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #564 on mailing card.

WHAT'S NEW

Product Literature

• The new **Hill-Rom Contemporary Line of Hospital Furniture** designed by Raymond Loewy and color styled by Howard Ketcham is featured in a catalog anounced by Hill-Rom Co., Inc., Batesville, Ind. The 126 page catalog has a spiral ring binder for flat opening. Complete room groupings are described and illustrated in color and there are individual views of the various items shown in the room scenes. With each room grouping, for example, the three different beds which may be used with the groupings are illustrated. Specialty and accessory items are also featured along with detailed technical and construction data and parts drawings.
For more details circle #565 on mailing card.

• Answers to many specific questions on the applications and uses of ultra violet black light are provided in a new 16 page brochure recently released by the Burton Manufacturing Co., 11201 W. Pico Blvd., Los Angeles 64, Calif. Factual information included in the brochure on **"Ultra Violet Black Light, the Newest Medium of Science,"** includes how it is used as an aid in treatment and diagnosis by hospitals and professional men, information on its uses and potentialities in research and scientific laboratories, together with charts and general data.
For more details circle #566 on mailing card.

• **Catalog 58** covers the full line of Nightingale Ajusco lighting fixtures available from Adjustable Fixture Co., 104 E. Mason St., Milwaukee 2, Wis. Full descriptive information and illustrations of bedlamps, ceiling fixtures, desk and table lamps, floor lamps, infrared lamps and torchieres are included.
For more details circle #567 on mailing card.

• A portfolio of the **ten catalog sections of lighting equipment** which have been introduced by The F. W. Wakefield Brass Company, Vermilion, Ohio, is now available. Brevity of copy covering the modern, efficient fixtures is supplemented with effective drawings. The catalogs cover the Wakefield Ceiling and the full line of modular lighting equipment developed by the company.
For more details circle #568 on mailing card.

• **Bulletin No. 71,** published by Cecilware-Commodore Products Corp., 206 Canal St., New York 13, gives descriptive information on 28 different griddle combinations, stoves and fryers for institutional use.
For more details circle #569 on mailing card.

• **"Hard Vulcanized Fibre Trucks and Receptacles"** for efficient maintenance in institutions are described and illustrated in a new 12 page catalog issued by National Vulcanized Fibre Co., Wilmington 99, Del. Included is information on trucks for linens, laundry and waste disposal applications.
For more details circle #570 on mailing card.

• **"Skytrol Glass Blocks for Toplighting your Buildings"** is the title of a new eight page catalog announced by Pittsburgh Corning Corp., 1 Gateway Center, Pittsburgh 22, Pa. Prepared as a reference manual for administrators, school planning committees, architects and engineers, the illustrated catalog contains information on physical performance, technical data on light transmission and insulation values, installation detail drawings and complete specifications.
For more details circle #571 on mailing card.

• The facts behind slippery floor accidents are told in a humorous vein in a new booklet released by Walter G. Legge Co., Inc., 101 Park Ave., New York 17. Entitled **"Mr. Higby and the Gremlin,"** the 16 page illustrated booklet tells how safety records can be improved while eliminating wasteful maintenance practices at the same time.
For more details circle #572 on mailing card.

• The story of the **Heat Recorder-Totalizer** for the efficient operation of any heating system is told in a folder released by the Heat-Timer Corporation, 657 Broadway, New York 12. How the Time Totalizer computes and registers the total hours of burner operation, and the automatic record of the operations of the heating system recorded on tape are discussed in the folder. Continuous supervision is afforded by the instrument which is easily installed in any heating system and effects savings in fuel and labor.
For more details circle #573 on mailing card.

• The problem of sudden power failure in the hospital and how it can be prevented is the subject of a booklet published by Caterpillar Tractor Co., Peoria, Ill. Entitled **"The Hospital Standby,"** the booklet tells of power failures in hospitals throughout the United States and Canada and how the protection of standby power kept them operating normally.
For more details circle #574 on mailing card.

• **"Waltzing Mice"** is the newest in a series of medical film available from Sandoz Pharmaceuticals, Hanover, N.J. The 15 minute sound film demonstrates pharmacological experiments dealing with the effect of various ergot alkaloids and lyseric acid derivatives on laboratory mice which congenitally waltz or dance because of a disturbance in the coordinating function of the brain.
For more details circle #575 on mailing card.

• **Catalog Q,** describing medical instruments for use with radioisotopes, has been announced by Nuclear-Chicago, 229 W. Erie St., Chicago 10. The 12 page catalog describes current diagnostic and therapeutic uses of radioisotopes and includes a number of instruments recommended for various applications.
For more details circle #576 on mailing card.

• Steam cooking for large and small kitchens using Steam-Chef or Steamcraft steamers is discussed in a four page folder brought out by The Cleveland Range Co., 3333 Lakeside Ave., Cleveland 14, Ohio. Entitled **"Steaming Is Better,"** the folder gives the advantages, facts and specifications of steam cooking.
For more details circle #577 on mailing card.

• The story of **Finnell Scrubbing, Waxing, Polishing and Mopping Equipment** is told in a four page folder released by Finnell System, Inc., 1400 East St., Elkhart, Ind. Descriptive information and illustrations also cover waxes, sealers and cleansers manufactured by the company for institutional maintenance.
For more details circle #578 on mailing card.

• A comprehensive catalog covering its full line of custom made laboratory glassware is available from Corning Glass Works, Corning, N.Y. **Catalog No. CA-1** is fully indexed, each piece of "Pyrex" brand laboratory glassware being listed alphabetically for easy reference. Illustrations supplement the descriptive material.
For more details circle #579 on mailing card.

• **Catalog No. 151** is a guide to the selection of propeller fan type ventilating equipment available from Ilg Electric Ventilating Co., 2850 N. Pulaski Rd., Chicago 4. Specifications and other installation data are given on the line of propeller fans. The attractive 36 page catalog contains detailed illustrations of construction features and case study photographs picture a wide variety of installations.
For more details circle #580 on mailing card.

• The story of **"Federal's Dial Telephone Systems for Fast, Dependable Intercommunication"** is told in a folder released by Federal Telephone and Radio Co., 100 Kingsland Rd., Clifton, N.J. How the Federal system can be used to save time and money is discussed and information is given on dial intercommunication systems for every service requirement.
For more details circle #581 on mailing card.

• The new "packaged" **Lamson Airtube System** is described in a brochure released by Lamson Corp., 3100 James St., Syracuse 1, N.Y. The "packaged" system can be installed by the hospital engineering department and is simple to operate. Points up to 130 feet distant may be connected. Installation data is included in the brochure.
For more details circle #582 on mailing card.

• A complete and concise record of washroom maintenance is available in the **Washroom Survey Cards** brought out by Bobrick Dispensers, Inc., 1214 Nostrand Ave., Brooklyn 25, N.Y. The pocket-sized cards list all the items in the washrooms and simplify inspection and follow-up maintenance.
For more details circle #583 on mailing card.

PRODU[...]

Inde[...]

Key

504 Wedgelock Handles
The Aluminum Cooking Utensil Co[...]
Inc.

505 Spencer "C" Boilers
Spencer Heaters, Lycoming Div., A[...]
Mfg. Corp.

506 Mopping Buckets
Geerpres Wringer, Inc.

507 Whirlpool Bath
Jacuzzi Brothers, Inc.

508 Color Banded Gloves
Pioneer Rubber Co.

509 Compressor-Aspirator
Air-Shields, Inc.

510 Utility Cabinets
Crescent Metal Products, Inc.

511 Polio Lung Alarm
Electro-Alarm Safety Devices

512 Formica Protective Plates
Cipco Corp.

513 Miratone Tile
Armstrong Cork Co.

514 Turn-A-Page
Medical Equipment Laboratories

515 DV-22R Surgical Light
American Sterilizer Co.

516 Wardrobe Combinations
Maysteel Products, Inc.

517 Tumbler Dryer
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528 Cello All-Foam Positioning Blocks
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April, 1955

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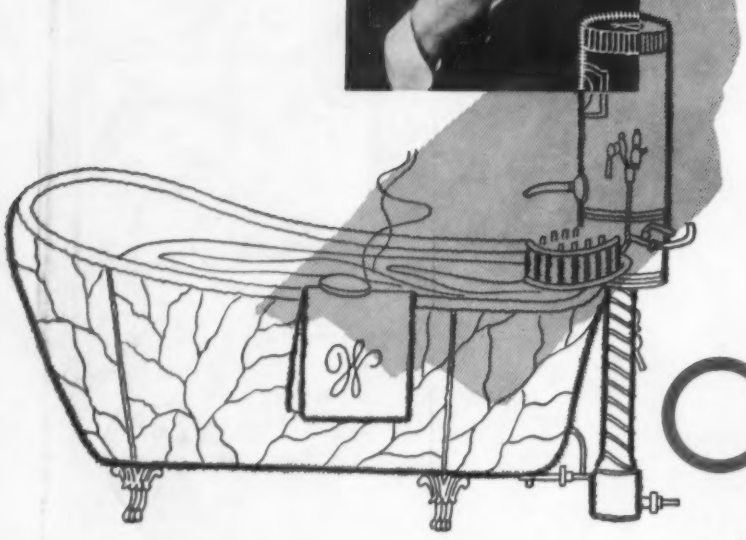

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